VA'S HEALTH CARE DELIVERY IN THE SOUTHEASTERN REGION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 8, 1983

Serial No. 98-29

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

26-829 O WASHINGTON : 1983

H761-2

COMMITTEE ON VETERANS' AFFAIRS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
BOB EDGAR, Pennsylvania
SAM B. HALL, JR., Texas
DOUGLAS APPLEGATE, Ohio
MARVIN LEATH, Texas
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
WAYNE DOWDY, Mississippi
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
FRANK HARRISON, Pennsylvania
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, JR., West Virginia
J. ROY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
BILL RICHARDSON, New Mexico

JOHN PAUL HAMMERSCHMIDT, Arkansas
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
DENNY SMITH, Oregon
PHIL GRAMM, Texas
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut

MACK FLEMING, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

BOB EDGAR, Pennsylvania, *Chairman*

DAN MICA, Florida
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
FRANK HARRISON, Pennsylvania
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, JR., West Virginia
J. ROY ROWLAND, Georgia
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
BILL RICHARDSON, New Mexico
THOMAS A. DASCHLE, South Dakota

JOHN PAUL HAMMERSCHMIDT, Arkansas
ELWOOD HILLIS, Indiana
GERALD B. H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut

CONTENTS

SEPTEMBER 8, 1983

	Page
VA's Health Care Delivery in the Southeastern Region	1

OPENING STATEMENTS

Chairman Bob Edgar	1
Hon. John Paul Hammerschmidt	4
Hon. Bill Nelson	5

WITNESSES

Frederick, Hon. William, mayor, City of Orlando, Fla	7
Cloutier, Daniel J. Sr., national service officer, AMVETS	57
Prepared statement by Mr. Cloutier	117
Crotty, Hon. Richard T., member, Florida House of Representatives, and chairman, Orange County Congressional Delegation	8
Prepared statement of Mr. Crotty	69
Doncaster, Kenneth E., legislative chairman, Department of Florida, Veterans of Foreign Wars	56
Prepared statement of Mr. Doncaster	113
Felices, Maj. Gen. Salvador E., USAF (retired), commissioner, State of Florida Commission on Veterans' Affairs; accompanied by Michael Hahn, executive director, Florida Commission on Veterans' Affairs; and Randy Touchton, staff director, Florida House Committee on Veterans' Affairs	16
Prepared statement of General Felices	81
Frederick, Hon. William, mayor, city of Orlando, Fla	7
Lukas, Connie, president, Central Florida Chapter, Paralyzed Veterans of America, Inc	59
McCollum, Hon. Bill, a Representative in Congress from the State of Florida	11
Prepared statement of Congressman McCollum	75
McDowell, Harry F., state commander, Florida American Legion; accompanied by Tracy Taylor, chairman, Department of Florida Veterans' Affairs and Rehabilitation Commission, the American Legion	51
Prepared statement of Mr. McDowell	101
McLeod, Charles M., legislative committee member, Disabled American Veterans, Department of Florida	55
Prepared statement of Mr. McLeod	109
Moench, Maj. Gen. John, USAF (retired)	62
Prepared statement of General Moench	133
Moody, Sam, member, American Ex-Prisoners of War	60
Prepared statement of Mr. Moody	119
Silverblatt, Dr. Charles, director, VA outpatient clinic, Orlando, Fla	46
Thompson, Donald B., director, southeast region, Department of Medicine and Surgery, Veterans' Administration; accompanied by Richard F. McElligott, Director, VA Medical Center, Bay Pines, Fla.; Richard Whittington, M.D., Acting Director and Chief of Staff, VA Medical Center, Gainesville, Fla.; Howard M. Ruppen, Director, VA Medical Center, Lake City, Fla.; Thomas C. Doherty, Director, VA Medical Center, Miami, Fla.; and John T. Riggin, Jr., M.D., Chief of Staff, James A. Haley, VA Hospital, Tampa, Fla	23
Prepared statement of Mr. Thompson	85

MATERIAL SUBMITTED FOR THE RECORD

Statement:

	Page
Arthur, Donald J., past national commander, Military Order of the Purple Heart	154
Bennett, Hon. Charles E., a Representative in Congress from the State of Florida	74
Land, John H., mayor, Apopka, Fla	164
Madden, William F., mayor, Palm Bay, Fla	165
McGee, Wilson, president, Wilson McGee Management, Inc., Orlando, Fla	168
Stallman, Arnold S., Cocoa Beach, Fla	170
Whittier, Robert W., mayor, Oviedo, Fla	171
Written committee questions and their response:	
Chairman Edgar to Veterans' Administration	98
Hon. John Paul Hammerschmidt to Veterans' Administration	45

VA'S HEALTH CARE DELIVERY IN THE SOUTHEASTERN REGION

THURSDAY, SEPTEMBER 8, 1983

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:33 p.m., in the Aviation Authority Board room, 2d floor, main terminal, Orlando International Airport, Orlando, Fla., the Hon. Bob Edgar (chairman of the subcommittee), presiding.

Present: Representatives Edgar, Penny, and Hammerschmidt.

Also present: Representatives Nelson and McCollum.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order.

Ladies and gentlemen, I am Congressman Bob Edgar and I am chairman of the Subcommittee on Hospitals and Health Care. I know that we have a small room and we invite those in the back to come forward. We have some standing room on the two corners. We apologize for the inconvenience of the size of the room, but we hope that the quality of the testimony and our participation here today will be of help to all of us in understanding the needs for care of the veterans' community in this area.

In January of this year I became chairman of the Subcommittee on Hospitals and Health Care. I have served on the House Veterans' Affairs Committee for the last 9 years. The Subcommittee on Hospitals and Health Care is a subcommittee of 21 members of the House Veterans' Affairs Committee. Our ranking Republican member is here, John Paul Hammerschmidt, who is not only the ranking member of the subcommittee but also the ranking member of the full House Veterans' Affairs Committee. We will hear his opening statement in a moment.

Also joining us is Congressman Tim Penny from Minnesota, who is a new Member of Congress and anxious to look at the needs for veterans throughout the country. We appreciate his taking the time to be part of the hearings today.

Also with us is Congressman Bill Nelson, who is the Congressman from this particular area. Joining us a little later will be several other Congressmen from the immediate area.

I am going to read an opening statement, which is not as brief as I would like it to be, but it will hopefully describe for you what the

purpose of our hearing is today. Then I will yield to my colleague, John Paul Hammerschmidt, for an opening statement, and my other colleagues, and then we will begin to hear from our witnesses.

Let me preface my opening statement with a comment that is not included in the official statement but comes to me as a result of looking at some of the press accounts of our visit here. We are going to hear a lot of testimony with reference to the need for a new hospital in the Orlando area. We are going to hear different veterans' organizations choosing up sides in terms of a site for that hospital.

I want to indicate to you, as the chairman of this subcommittee, that this is not a site-selection committee. The site selection will be done by the Veterans' Administration, by the professional staff, who will look at the strategic location in this region. I think, if we spend all of our time listening to arguments as to where it ought to be located, you may find yourself confusing the issue a little bit and perhaps jeopardizing the real quality of the information that we need to receive as to the real purpose of our hearing.

We spent some time yesterday in Bay Pines looking at a brand new hospital that was built there. We have just come by airplane from Palm Beach where we anticipate within the next few years that a hospital will, in fact, be constructed. That hospital is now part of the VA's 5-year plan. The second location in the State of Florida for a hospital is this region. I have every full confidence that a hospital will, in fact, be constructed here and we're going to need the cooperation of all of the counties and all of the communities in this area to make sure that that hospital stays on the time line and on target and is, in fact, constructed. A large political debate over the location at this point would jeopardize keeping that in the pipeline. We will talk about that some more as we proceed.

Let me just read my opening statement and then we will hear from John Paul.

On September 6, the first day of the field trip, the subcommittee heard from veterans in the New Port Richey area of Pasco County concerning VA's health care delivery in that location. Yesterday we toured the VA Medical Center at Bay Pines and this morning visited the VA outpatient clinic in Riviera Beach. Following this hearing, members of the subcommittee will tour the VA outpatient clinic in Orlando.

This afternoon we will hear testimony from a number of witnesses to be introduced, and we look forward to that particular testimony.

This series of oversight hearings is particularly important at this time due to the crossroads that the Veterans' Administration health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services to eligible veterans. In the five VA medical centers in Medical District 12, there has been allocated over $73 million and 7,860 employees to provide health care to eligible veterans. The medical district served 1,351,045 veterans in fiscal year 1982. The Florida veteran population was 1,377,470 veterans in 1980. It is projected to be 1,593,370 veterans in 1990. Over the same period, the number of veterans age 65 or older will increase by 41.2 percent.

Florida is one of the only two areas in the Nation where the veteran population is projected to increase in future years, while the veteran population is decreasing in the Nation as a whole. However, due to the increasing age of Florida's veterans, the population is projected to decline significantly by the year 2010, after peaking about the year 2000. These population dynamics affect planning for the VA medical facilities in that care must be taken not to create expensive facilities which may not be needed in future years.

Nationwide, the VA has estimated that demands placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over the age of 65 will be veterans. Right now, due to the significant unemployment in the Nation, more and more veterans are coming to the VA for the first time. These facts indicate that we not only have a present problem, but also a future problem in maintaining the quality and quantity of care. The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also hospital care resulting from acute episodes of chronic illnesses in the older veteran. We must cope with these present demands, but more important we must be prepared to accommodate the future demands on the system as well.

For the past 2 years the Veterans' Administration's Department of Medicine and Surgery has been in the process of developing a new planning methodology called medical district initiated program planning. This planning process employs a decentralized population based planning methodology approved by the Office of Management and Budget, OMB, and the General Accounting Office, GAO, which involves medical districts in planning for future health care requirements based on projections of eligible veterans. This highly efficient and accurate system is used nationwide to determine VA health care requirements and was used extensively in the development of the final report on future bed needs and potential sites for the new VA hospitals here in Florida. Based on the approved standards and criteria, the report identified four proposed hospital sites in the following counties and areas: Palm Beach, Brevard, Florida's Panhandle, and Lee. These determinations were made solely by VA planners based on the MEDIPP process.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress. Having said this, however, I do not believe that veterans' organizations and individual veterans can sit back and do nothing. The VA health care and other benefit programs have been enacted by the Congress as the will of a grateful Nation for the sacrifices of veterans made in serving in the Armed Forces of the Nation. But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities. The VA medical budget for fiscal year 1984 is aproximately $8.1 billion. However, that figure represents only about 2.5 percent of all national health care expenditures. At the same time, the VA has provided part of the training, through its affiliations with the private medical school communities, for more than one-half of all health care professionals in the United States.

VA researchers have already received two Nobel prizes in medicine. The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension, and psychiatry to name only a few.

The five medical centers in district 12 have been allocated over $6.85 million for VA funded research. The VA is the Nation's largest health care provider with 172 strategically located hospitals and 226 outpatient clinics serving as the primary backup to the Department of Defense's medical system in time of war or national emergency. The investment made in the VA is more than returned in kind.

I would now like to ask Congressman John Paul Hammerschmidt from Arkansas to share with us his opening remarks before we begin.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I have a rather brief opening statement, but before I give it, it might be appropriate to tell a little anecdote that I remember in my experience on this committee.

A few years ago, maybe 10 years ago, VA had on line planning for eight veterans' hospitals. I'm going to mention something parochially here because one of those was located eventually in Arkansas, which will be completed and dedicated about this November. But the point I want to make is that the way they were listed, similar to the 5-year plan now, Portland, Oreg., had a spot on there of number four. The people in Portland, Oreg., got into a great dispute over exactly where that hospital was going to be located. So as a result of that, Arkansas slipped in ahead of them and Portland's hospital was delayed 2 years.

I only mention that things like that do happen, and I recall it. I am delighted that this area is being chosen and is on the list for a hospital to serve all the people in this area.

Now I will give my brief opening statement.

Mr. Chairman, first may I congratulate you on scheduling this series of field hearings for our Subcommittee on Hospitals and Health Care. Such hearings give our members an insight into the VA medical care program which we simply cannot obtain by viewing that program only from the Washington scene. This is particularly true as to Florida, where the influx of veterans from other parts of the country is very extensive and where the problems relating to aging veterans are very much in evidence.

Mr. Chairman, you have outlined the scope of our visit to Florida. We have seen, or will see, two VA outpatient clinics and the new, beautiful VA hospital and nursing home at Bay Pines, which incidentally was number one on that list of eight, which was just opened fairly recently. We visited with veterans at outreach centers. We have also visited the area of Palm Beach, where still another new VA hospital is to be built. And now we will be obtaining facts and figures with respect to VA medical needs in this State

from veteran leaders of Florida and Veterans' Administration officials.

When our visit is concluded this evening, I am confident that we will be armed with extensive information which will be of material assistance as we pursue our Veterans' Affairs Committee activities back in Washington.

Mr. Chairman, Florida is a reflection of the entire veterans' medical program in our country. Here are five hospitals and several outpatient clinics; here is a domiciliary program; here are deans' committees, good medical school affiliations, good research programs, vet centers for Vietnam veterans, and an excellent volunteer program nourished by the extremely active veterans' organizations and their auxiliaries. Here, too, are the many problems associated with VA medical care, such as the need for computerization of our hospitals, the need to prepare for future needs of aging veterans, and the need to cope with exploding increases in the veterans' population. We couldn't come to an area of the country more likely to expose us to the kind of information we need to do our jobs.

So again, I congratulate you, Mr. Chairman, for having these hearings. I am delighted to be with Bill Nelson, certainly, our distinguished colleague who has made known the needs of his area so very well. I look forward to hearing from our distinguished witnesses.

Finally, Mr. Chairman, I want to mention something that is dear to all of us. We are in the home State of Claude Pepper. I serve with Claude Pepper on the Select Committee on Aging. Today is his 83d birthday and I know that all of us want to join together in wishing him a happy birthday.

Mr. EDGAR. Very good. I share that sentiment of birthday greetings for Claude Pepper. I think there is probably no Member of Congress that, regardless of his positions on issues, is more respected than Claude. I celebrate with the people of Florida his birthday.

I would now like to yield to Congressman Bill Nelson. Let me just indicate that these hearings, while they are regional hearings going across the country, would not have taken place in this area had it not been for his leadership and his request that we come and listen to the concerns of this community. We are pleased to have him here as part of the hearing today, and I yield to him at this time for any opening remarks that he may wish to make.

STATEMENT OF HON. BILL NELSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. NELSON. Thank you, Mr. Chairman, and members of the committee, John Paul.

We are all gathered here in a common purpose today—the beginning of the culmination of an awful lot of work over the course of the last 4½ years by this Member of Congress in getting the VA to change an existing nation-wide policy, that being that there could be no location of a VA hospital unless it was colocated with a medical school. Thus we have our hospitals existing in places colocated with medical schools in Gainesville, Tampa, and Miami.

For you, Mr. Chairman, to be so gracious and to accept my invitation to come here, hard on the heels of the first promising report that indicates a change within the VA of that nationwide policy, because that report recognized the need for four hospitals in Florida between now and 1995 and specifically identified as one of the priority hospitals the location because of the concentration of veterans in east-central Florida.

We all have the human tendencies to want, once good news comes such as that major policy change, to immediately focus in on where our particular interest would like the location. As people have come forth to me trying to get me to endorse a specific site, I explain to them that I will not because it is inappropriate. What is appropriate for this Congressman is to bring the attention of the needs of veterans for those facilities in this region and to get the VA to follow through. That is why I am so thankful to you, Mr. Chairman and members, for coming here, as an additional opportunity of focusing on these needs.

Now, we are not only talking about the needs of a hospital; we're talking about all medical facilities, which your subcommittee has jurisdiction. We're talking about a nursing home, we're talking about an overloaded VA outpatient clinic, of which at my personal request 4 years ago the VA Administrator came here, inspected it, and immediately set about on a program of doubling the capacity of that outpatient clinic, which we knew when it was completed it was going to be overloaded again because of the extraordinary number of veterans moving to Florida, as you cited in your statistics in your opening statement.

Human nature being what it is, we have a tendency to get up tight about it ought to be in this location or that location. Mr. Chairman, I appreciate your words of suggestion and advice here, that we have a long way to go before we get the Veterans' Administration to say they're going to have a hospital here. That, I would hope, would occur somewhere in the course of the next 2 years. Once that is done, then it is the appropriate role for the Veterans' Administration, through their professional staff, to then search about and make a specific site selection. That will come in the future, as I understand it, somewhere, if all goes well and we get identified as a place for a hospital, some time in the next 2 to 3 years. So for you to be here, Mr. Chairman, and help focusing in on our needs and the attention to these problems, and for all of these veterans here with whom I have worked over the last 4½ years, united in this effort, in calling attention to the medical facility needs of veterans in east-central Florida, I am profoundly grateful and I am profoundly grateful to you.

Thank you, sir.

Mr. EDGAR. Thank you.

Congressman Penny, do you have any opening comments at this point?

Mr. PENNY. I think I will save them, Mr. Chairman.

Mr. EDGAR. Very good.

Before moving to the Mayor of Orlando and one of our other colleagues who is here to testify, let me introduce Duane Schultz, who is the district representative for Senator Paula Hawkins. Duane, would you stand up so you can be recognized? If anyone wants to

talk with Duane, they can. Duane is here representing Senator Hawkins and she has requested that we share the information with her that is taken in this hearing. I am pleased that her staff representative is here also to take the information.

Mr. EDGAR. I would like now to call Mayor Frederick of Orlando to the witness table, and I wish that Hon. Richard Crotty would also join him at the table, who is our first formal witness.

Mayor Frederick, we are pleased to be in your area. We are pleased also to give you an opportunity to lead off our witness list today. Thank you for coming.

STATEMENTS OF HON. WILLIAM FREDERICK, MAYOR OF THE CITY OF ORLANDO, FLA.; AND HON. RICHARD T. CROTTY, MEMBER, FLORIDA HOUSE OF REPRESENTATIVES AND CHAIRMAN, ORANGE COUNTY CONGRESSIONAL DELEGATION

Mayor FREDERICK. Chairman Edgar and distinguished members of the committee, I am delighted to have you in Orlando and I want to welcome you to our city. I am very pleased that you would have the opportunity to come and take testimony on this very important project to not only the city of Orlando but to central Florida.

I am here for basically two purposes, first as a veteran myself, to support the importance of this project. You may have had a chance to look at this morning's paper, where you see that Florida is forecast to be the third most populous State in the Nation by the year 2000. In the timeframe of this particular project, these growth statistics from seventh to third become highly relevant.

Additionally, although I am sure this is in the record prior to these comments, the fact that Florida over the past 10 years has enlarged its veterans' population by some 43 percent, I think it is a precursor of things to come. We are one of three States where, as you well know, the growth of veterans is on the increase. So we think this is a marvelous trend, a marvelous prospect for this area, and we certainly add our support to the propsect that the central Florida area will be the recipient of one of several hospitals to come to Florida.

Again, I listened carefully to my good friend, Bill Nelson, and as mayor, I am sure you can understand my enthusiasm not only for the project but to at least introduce a couple of comments on the opportunities for Orlando as a site. I won't dwell on that at length, but at the University of Central Florida we do have some land. There are some other sites. We think this would be a marvelous thing for the more than 80,000 veterans that reside in this area. The population of veterans is here and we think it is appropriate to avoid a lot of congestion, some liabilities, frankly, that might occur if the site is not the optimum one. We do clearly support the project ahead of the site, but I think that once that hurdle is overcome, that we would very much like to encourage a careful look here with the hopes that maybe this hospital, when it is achieved, indeed might help us locate a medical school in this area, that the two could then work in conjunction and add vitality to the project.

So I thank you for being here. I welcome each of you and hope you have a pleasant stay and come back soon.

Mr. EDGAR. Thank you very much. We appreciate, Mayor, your taking the time out of your busy schedule to come and welcome us and to give testimony to our subcommittee.

Do any of my colleagues have any comments they would like to share with the mayor at this time? Thank you very much.

I might mention that Mayor Robert Whittier of Oviedo and Mayor John Land of Apopka have submitted statements for the record. I would like to ask unanimous consent that their statements be made a part of the record. Without objection, so ordered.

[The statements of Mayor Land and Mayor Whittier appear at pp. 164, 171.]

Mr. EDGAR. Thank you very much, Mr. Mayor. We appreciate your testimony. You are welcome to sit and listen——

Mayor FREDERICK. I will stay for my good friend's comments, if I may.

Mr. EDGAR. I would now like to introduce Hon. Richard Crotty, who is not only a member of the State House from Florida but also the chairman of the Orange County Congressional Delegation. I am not sure what kind of an organization that is, but we welcome you——

Mr. CROTTY. It's a good one. [Laughter.]

Mr. EDGAR. We welcome you here and we are pleased to have you lead off today.

STATEMENT OF HON. RICHARD T. CROTTY

Mr. CROTTY. Thank you, Mr. Chairman, and members. I am Richard Crotty and I represent district 37 in Orange County, which is the south and east part of the county. I would like to welcome you here.

I am speaking to you as a representative from eastern Orange County, but I would like to welcome you as chairman of the Orange County Legislative Delegation.

In further welcoming you, I would like to commend Congressman Nelson for arranging for your visit with us today. We appreciate that and we appreciate his keen interest in the needs of the veterans in the east-central Florida area.

From the outset, let me just say that I am in support of Congressman Nelson's efforts along with the other members of our local congressional delegation, Congressman McCollum and Senator Hawkins, in securing a facility in the east-central Florida area. And while I understand you don't want to dwell too long on the site aspect of this particular decision, I have submitted for you some comments that would indicate my preference for an east Orange County location verus farther east in the east-central Florida area.

Specifically, these would be offered to you as rebuttal for some of the findings that were offered in the final report on future bed need and potential site for new VA hospitals in Florida which you, Mr. Chairman, alluded to earlier. Specifically, my rebuttal would be to improving the accessibility to inpatient care for the greatest number of veterans, road accessibility, mileage data, the negative impact caused by existing facilities, as well as some general observations, some of which were made earlier by the mayor.

The first rebuttal I would like to offer relates to accessibility to the greatest number of veterans. The Orange County primary service area will accommodate 8,318 more veterans than the Brevard PSA, and this is according to September 1982 figures. That number jumps up to 9,860 in 1995.

The VA's 1995 population projection—and this is using the VA statistics—allowed for an 18.8-percent increase in veteran growth. This was done in both counties, however, using the same figure, assuming that Orange and Brevard would grow at the same rate. Yet Orange County's average yearly projected growth to the year 2000 is almost 29 percent larger than Brevard's growth projection. This growth differential basically would boost Orange County's veteran population by 24 percent over Brevard's.

There are some fairly dramatic differences in these numbers to the year 1995, and I would like to point out to you, in just highlighting the report I have submitted to you, that the projected county population from the University of Florida Statistical Abstract Report indicates that by the year 2000 Brevard County will have 349,200, whereas Orange County will have 668,700, an average yearly growth for Brevard County of 6.3 percent and for Orange of 8.13 percent. So you see a basic difference in the rate at which the east Orange County area is going to grow versus the Brevard County area. I think that is something that should be taken into consideration.

The next rebuttal I would like to offer is relative to road accessibility. In your packet you have a map here that shows the basic area that we have under discussion today and the road network. The areas are fairly equal. You will see here where it is stamped the airport toll plaza, and this is where you are located right now. The areas are fairly equal in interstate highways. We have four running through the west side of this map. What that indicates to you is the metropolitan Orlando area—that's three counties, Seminole, Orange, and Osceola, with Interstate 95 running down the coast. So in interstate highways, it is relatively equal.

We have, however, the Florida Turnpike coming through Orange County, and you can see that this one picture will indicate to you the number of roads and the road network on this side of the map versus this side. I think just a visual view of it would indicate a preference for the more western area.

Looking just at that western area, you can see another map in your packet. One indicates the extension of our East-West Expressway here in Orange County, which is a vital link to east Orange County. That is going to start next month and will end 1,500 feet from the Alfaya Trail which leads to our university that the mayor talked of earlier. An outer belt, the eastern extension, should be finished around the year 1989, which is about the same time that any hospital is contemplated for.

Next, we're not talking just about roads but about straight mileage. According to 1982 mileage-versus-population statistics—and these are the figures supplied by the VA again—64 percent of the veteran population from the Brevard County PSA live closer to the Orange County PSA. Thirty-six percent of the Brevard PSA, of the total veteran population, and an overwhelming 64 percent of the

Brevard PSA, live in the Orlando portion or are closer to the Orange PSA.

Next there was some discussion about negative impact on existing facilities, and once again I have offered a great deal of information to you that I hope you will have a chance to look at on your trip back to Washington or when you return. But I think the most key thing here was mentioned by the chairman earlier, and that is that the national population by 1990 in terms of veterans is on the decrease, where in Florida there is actually a 12-percent increase. Inpatient demand in Florida, like the rest of the nation, far exceeds available services. Thus, this statement should not be a factor because the veteran population in Florida is large enough to compensate for any impact on Gainesville or Tampa.

What would happen here is actually, because there is a waiting list, the building of a hospital anywhere in this east-central Florida area is not going to take bed space away from the other facilities, but just make that waiting list a little bit shorter. The statistics I have provided for you indicate the very long waiting list.

Finally, and in closing, let me just reiterate what the Mayor offered to you earlier. In east-central Florida we have a major institution, the University of Central Florida, which picked the Orlando area, I believe, for many of the same reasons that we would advocate the east Orange County area for a VA hospital. Currently there is a College of Health which teaches nursing and other health-related occupations. We think this would go very well with the development of a VA hospital. As the mayor mentioned, there may be an opportunity. With this program in place and with the possibility of having a hospital closer to the university than 30 or 40 miles, for the development of a medical school.

With that, Mr. Chairman, and members, I thank you for the opportunity of meeting with you today. Unless there are any questions, I would wish you a safe trip back to Washington and I appreciate the opportunity.

[The statement of Hon. Richard Crotty appears at p. 69.]

Mr. EDGAR. Thank you very much for your testimony. I don't have a specific question but I do have a comment. I feel a little bit like the wise old King Solomon who was confronted with two mothers and one child, and they started pulling in both directions. King Soloman decided that the way to solve the problem was to cut the child in half. I feel like we should put a couple of beds here and a couple of beds there and solve your problem.

As I indicated, we are not a site selection committee. Your statements and your information are helpful. My hope is that both of you will transport your information to Harry Walters, who is the new Administrator of the Veterans' Administration. Working through your congressional delegation, you need to present a unified front within the VA for all of the arguments that you're making, and you need to impress upon the technical staff there the importance of the arguments you make.

It may sound strange to those in the audience and to some of you in the State Legislature that we would take this position about site location, but I have to assure you that in years past, when Federal budgets were not in deficit as they are at this point, or when there were resources available, or when the Congress did a lot more

porkbarreling of particular projects, hospitals became located in areas that didn't have populations.

We all know of the example that in the DOD medical system is so gross in present history, is the F. Hebert Hospital in Louisiana that was established. For a long time there was very little use of that particular facility. It was established because a Member of Congress had gotten elected, stayed a long time, and they honored him by putting the hospital in his area whether they needed it or not. A lot of egg was on people's faces because, in fact, the need was not there.

What I hear from your statement in a very strong way is that there is a need and that the number of veterans in both of these counties and both of these areas is extensive. The Palm Beach Hospital is now included in the VA 5-year plan, and that's the magic. Once it gets put into the 5-year plan, that means you can announce that the hospital is going to be constructed and the site selection is made. The indication in the earlier 30-year projection of VA medical needs in Florida is that this is the second likely spot for a hospital to be constructed. We celebrate that but that is still a very preliminary announcement. I think we need now to work to make sure it became part of that 5-year plan and the information that you and the mayor and others will share today needs to be transported to the Administrator of the VA who, with his staff, will analyze it and make that site selection.

You have made a good statement. You have indicated your strong preference, and I respect the fact from your perspective that is the best site. We just have no way of determining whether you're right, wrong, or what the situation is. We appreciate the fact that you're going to make that contribution.

John Paul?

Mr. HAMMERSCHMIDT. Mr. Chairman, I only want to thank Mr. Crotty and Mayor Frederick for their very fine statements. I see we have had a distinguished colleague join us here and I know you're getting ready to recognize him, so I won't take any more time. But we do thank both of you for appearing here today.

Mr. EDGAR. Do any of my other colleagues, Bill or Tim, have any comments? Thank you very much.

Mr. CROTTY. Thank you, Mr. Chairman.

Mr. EDGAR. I would now like to recognize the Honorable Bill McCollum, who is one of our colleagues in Washington. Bill, we are pleased to have you as an "adopted" member of our subcommittee today. We know that you have an opening statement and we look forward to hearing it.

STATEMENT OF HON. BILL McCOLLUM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. MCCOLLUM. Thank you very much, Mr. Chairman. I am delighted that you invited me to participate in these field hearings, along with my colleague, Bill Nelson. We share a common interest in this region of Florida, but we share an overriding interest with your whole committee on the interest of veterans in our country and our State. My good friend and colleague to my left here, John Paul Hammerschmidt and I have been working together on many

matters for quite some time and I am just delighted that you came to join us, along with the gentleman from Minnesota. We are pleased you are here today.

I would like to comment on things in light of some of the statements you just made, which I think we in Congress, and certainly myself and Bill Nelson are very aware of. I have feelings that are very strong about certain issues on veterans' matters and I have submitted those from time to time, including testimony before your committee—your subcommittee, as a matter of fact, in June of last year. As recently as this week I have been in contact with Administrator Walters about some of the issues here today and have submitted to him what I am going to present to you.

We in Florida—and I think I can speak for all of us here—are very pleased with the fact that we have a 30-year study that was commissioned. We are very pleased that Administrator Walters has recently designated in the 5-year plan Palm Beach County to get a new VA hospital. And we are very pleased that the medical district plan includes so many recommendations toward future construction sites of beds and health facilities in Florida.

However, while the 30-year plan and the other efforts that have been made clearly document the unique and critical nature of the Veterans' Administration health care shortage in Florida in the coming years, the analysis, conclusions, and recommendations flowing from these studies and plans will offer an opportunity for reasonable men to differ about the conclusions that can be drawn from the same facts.

The veterans population growth projections for Florida in my judgment is significantly understated in the 30-year plan and in the medical district plan. According to Government figures printed today in the Orlando Sentinel, by the year 2000 Florida will be the third largest State in population in the United States, doubling its present population. It is reasonable to project, Mr. Chairman, a possible doubling of the veterans population, at least a 50-percent growth and not 11 percent in the next few years, or 17 percent, as some of the other figures indicate.

Using the 30-year study's own estimate that 41 percent of Florida's veteran population will be 65 years of age and older by the year 1990, and applying it to the more realistic veterans population growth projection, one can readily see that the recommended increase in beds, and additional health care facilities will fall far short of keeping pace with the growth in Florida.

The medical district plan and the 30-year study appear to premise their analysis and conclusions on a policy judgment that extreme caution should be used to avoid overbuilding and winding up with underutilized capacity after the year 2000, when the veterans' population is projected to begin to decline. As a result, the shortages of beds and facilities for veterans in Florida is likely to be even greater than would result simply from an underestimation of the projected growth.

However, the most serious defect that I see in the study and in the district plan is the failure to adequately deal with and meet the presently existing and near-term shortages of health care, beds and facilities for veterans in Florida. Except for the West Palm Beach Hospital, the psychiatric beds and an effort to get the nursing facil-

ities started in this State, most of the construction of new beds and facilities would not be completed until well after 1990.

Now, I recognize all the budgetary considerations and all of the other debates within the entire Congress today over these issues. But the extreme shortage of beds in this State is real, and it is clearly demonstrated when one contrasts the available bed usage here and elsewhere in the country. Veterans with service-connected disabilities get bed priorities, as well they should. However, in Florida they take up a much higher percentage of the total number of available beds than any other part of the country, which means that very few beds are available for the average veteran who would otherwise be entitled to them if he were living in another region of the country.

Despite the fact that we have a very large military retired population, the new naval hospital built here in Orlando recently—which I commend my colleague and his predecessor and mine for working on—was designed only to serve the active duty military population needs. The fact remains that it is inadequately serving those needs now because of the extreme shortage of doctors and medical personnel that the naval service has today, with the obvious result that retired military persons are added to the roles of those veterans who are demanding increased facilities and services as contrasted with many other regions of the country.

Mr. Chairman, the veterans of Florida have needs now, not in 1995 or the year 2000. The fact is that many of these people, by demographic projection, sadly will be in their graves by the time much of the construction that is recommended in the district plan is completed. Veterans of Florida need the timetable to be dramatically moved up on the building of these various items and beds in Florida, and for stopgap alternatives to be developed and to be provided for them, which they are entitled to. Congress must allocate the necessary resources to do this if we are to avoid a national disgrace. And while this committee, I know, is not the funding committee, certainly you are the most singly influential committee outside of Appropriations dealing with this problem. I really feel, having read these reports, studied them, dealt with them, talked to veterans, been involved in this process for the time I have in central Florida and in the State, that there isn't a more important message that we could send back to you today—the shortage in veterans' facilities in Florida is much greater than is being recognized or maybe admitted to for budgetary or other administrative reasons.

Now, I realize what we said before, that site selection is not the primary focus here today, and that we cannot deal with it in this committee. But I am sure the committee members are aware that quite a controversy has developed in east-central Florida since the medical district plan gave a tentative recommendation of Brevard County over Orange or Seminole County as a site for a VA hosipital to be constructed in the 1990's. As my colleague, Mr. Nelson, and I have related to you in the past, the controversy is present and we do need to discuss it. I feel compelled just to give a couple of comments and then listen to the witnesses which I thank you for letting me have the privilege to do.

26-829 O—83——2

I think sometimes in the heat of the moment we forget the most important things. The most important thing for east-central Florida veterans is the fact that the plan recommends a hospital for east-central Florida. The next most important thing is that this recommendation is just that. It's a recommendation. There is nothing final about any of this, not the site, not the county, not even the east-central Florida hospital itself.

In the coming months it is my fervent hope that all the interested parties in this room, in Congress, and in the VA will work together with regard to letting cool heads prevail so that we can come up with a site selection and become united in our efforts and go forward as soon as possible.

On the other hand, while I respect the judgment and hard work of those who worked on the district plan, and recognize that reasonable men may differ in analyzing the same facts, I strongly disagree with the site selection analysis in this plan and the conclusion that Brevard County is preferable to Orange or Seminole County for the location of a veterans' hospital.

From the standpoint of reasonable access, an appropriate location is either in Seminole County or Orange County. Both counties are more central and accessible to many more veterans in the east-central Florida region than Brevard County is. The central focal point of population growth and transportation in east-central Florida is Orange County, not Brevard. The State university for our area, as our friends just pointed out, is in Orange County, near the Seminole-Orange County line. This should be a focal point of concern here because there is a possibility of a medical facility somewhere, however remote, out there in the future. It is far more likely to be built near that university than anywhere else in east-central Florida.

There is another factor here. With the new naval hospital located in Orlando, and knowing of the policy and intent of Congress that facilities, equipment, and personnel be blended and shared to as great an extent as practical between veterans and military hospitals, it seems much more reasonable to place a new veterans hospital closer to the Orlando Naval Hospital than would occur if the hospital were placed in Brevard County.

Worries about a hospital in Orange County or Seminole County drawing significantly from the other major hospital facilities in Gainesville or in Tampa in my judgment are unjustified and should not be considered as a criteria in deciding between Orange, Seminole and Brevard Counties.

Either now, or before reapportionment, I have represented a good hunk of the territory involved in the questions of these various hospital service areas, including the new one. Feeling as I do about the area and knowing the transportation systems and the veterans, I feel my judgment on this point, as I have told Administrator Walters, is as good or better than most.

It is my hope that the data and the opinions gathered by your committee today, Mr. Chairman, will lead to constructive discussion among all the parties, including the local community, and the Veterans' Administration, the Congress, and all of us who have an interest in this matter, so that long overdue attention to veterans

concerns of the critical shortage of health care facilities in Florida can be addressed quickly and not be put aside.

As to the specific issue of site selection, we should be pleased if we are so blessed with getting a hospital. I hope that the minds of everybody will remain open so that we can discuss this reasonably and responsibly and we can join together on some common goal that we can all be proud of. The bottom line of all this is to serve the best interest of the veterans.

Again, I want to thank you for letting me participate and letting me make such a long opening statement. But I think it is very important and I thank you.

[The statement of Mr. McCollum appears at p. 75.]

Mr. EDGAR. Bill, we are pleased to have you here and we are pleased to receive your opening statement.

Let me just make two brief comments. First, one note that I did not mention in my opening statement. As we have traveled around Florida and studied the impact of the number of new veterans that are coming in, not only on a monthly and yearly basis—and Representative Dan Mica on our subcommittee always reminds us of the figure of 5,000 new veterans per month. Yesterday, in a press conference, he reminded us how many new veterans Florida receives every minute. [Laughter.]

I pointed out to him that the Congress of the United States has not overlooked that particular need. In the next 5 years we will spend approximately a little under $5 billion in veterans health care construction. A good chunk of that, more than the rest of the States combined, will in fact be expended here in the State of Florida. It clearly is not going to meet all of the needs, but a new facility will be built in Palm Beach, the renovation of a facility over at Bay Pines, and the beginning process of additional facilities, both outpatient clinics and other permanent facilities, such as a large hospital, will in fact be part of the future.

But I have to say that one of the points you made is real important to underscore, and that is that the needs for providing quality health care for veterans are not totally going to be met in the State of Florida by the construction of hospitals, even if we doubled, tripled, or quadrupled the amount of money that would flow into this area. We are going to have to look for innovative ways to provide and deliver health services. We were looking, for example, at the possibility of an outpatient clinic next to a community hospital, looking at the possibility of other innovative health technologies to provide care for veterans, particularly those veterans who are in remote locations who find it very difficult to come to the urban centers. And we also know that nationally, with the renovation needs of our VA hospital facilities, the average age of which is 35 years, that limited dollars will be available as we move into the future. Again, I cautioned in my opening statement for you to avoid a fight over site selection at this time, before you're in the 5-year plan. I think it is a mistake for those of you who represent this area.

The process is an important process. You have been identified as an area for a hospital. It's a recommendation. That recommendation becomes solidified when it becomes part of the 5-year plan, as did the Palm Beach facility, and it is at that point that your work

with the Administrator is really critical so that the site selection is made in a timely and in an appropriate fashion. I commend you, and I know that both you and Bill, while you may have different views which are not always stated or outlined as to where the hospital ought to be located, there will be many other people who will have input to make into that site selection. My hope is that the best possible location will in fact be adopted.

But we are looking at creative alternatives and you will see a lot of reemphasis in our committee in looking at those new alternatives for health delivery.

Mr. MCCOLLUM. Mr. Chairman, you have made some very good points, and I wanted to commend you for that openness and frankness in your discussion as well as that awareness.

I am sure that my colleague, Bill Nelson, agrees with me, that we need to have some of these stopgap innovative measures soon in central Florida. If there is nothing else that I'm saying here, besides my other observations, that's it. We just need you all to get on with it, but more importantly, for the Veterans' Administration to get on with it right here.

Mr. EDGAR. Very good.

John Paul, do you have any comments at this point?

Mr. HAMMERSCHMIDT. Only that Bill, who is certainly one of our most able colleagues in the Congress, has just reemphasized some of the things that we have learned on this visit to Florida. We know your need is compelling, and it is now, and you can't really wait for brick and mortar to go up. So there probably will have to be a reallocation within the VA system itself of certain resources as it pertains to health care delivery around the Nation vis-a-vis that in Florida. That's coming through to us, Bill, and we appreciate your making it very clear in your statement.

Mr. MCCOLLUM. Thank you.

Mr. EDGAR. Are there other comments of my colleagues?

Our next witness will be Maj. Gen. Salvador Felices, who is the Commissioner of the State of Florida Commission on Veterans' Affairs. He will be speaking as a representative of the Governor of the State of Florida, Governor Graham. We welcome you here today and we are pleased to have you with us.

Our hope is that as you begin your statement you will identify those who are with you. The full text of your statement will be made a part of the record. We ask that you summarize your statement to about 5 minutes so that we will have an opportunity to ask you questions and be able to proceed with the other witnesses that are scheduled today.

STATEMENT OF MAJ. GEN. SALVADOR E. FELICES (USAF-RET.), COMMISSIONER, STATE OF FLORIDA COMMISSION ON VETERANS' AFFAIRS, ACCOMPANIED BY MICHAEL HAHN, EXECUTIVE DIRECTOR, FLORIDA COMMISSION ON VETERANS' AFFAIRS; AND RANDY TOUCHTON, STAFF DIRECTOR, FLORIDA HOUSE COMMITTEE ON VETERANS' AFFAIRS

General FELICES. Thank you, Mr. Chairman.

The people sitting with me, on my right is Michael Hahn, who is the executive director of the Florida Commission on Veterans' Af-

fairs, and on my left is Randy Touchton, who is the staff director of the Florida House Committee on Veterans' Affairs.

Mr. Chairman and gentlemen, I bring you greetings from Governor Bob Graham and his personal apology for not being able to attend the hearings today. I also would like to welcome you on behalf of the Florida Commission on Veterans' Affairs and the more than 1.5 million veterans that currently reside in our beautiful State.

Recognizing the fact that there are many others here today who wish to express their thoughts with respect to both the quality and quantity of available health care to veterans in Florida, my comments will be brief—and I will not comment on the site selection.

Mr. EDGAR. I thought maybe you would be neutral on that one.

General FELICES. As you probably know already, Florida is experiencing a rather pronounced growth in its population of resident veterans. With respect to the overall quality of health care available to these veterans, we have heard relatively few complaints. However, the quantity of available health care facilities is already below the national average and falling further behind each day. This is true in available beds per thousand veterans and in outpatient care.

Mr. Chairman, I am going to try to abbreviate as you asked me to. We have four items that we particularly wanted to talk about and we feel, as Congressman McCollum mentioned, that we are behind and falling behind each day. As Congressman Mica tells you, that we do have 5,000 veterans coming into the State each month, we have had some months where that figure has escalated to 11,000.

We believe that it is unreasonable to expect the level of available health care provided by the VA in Florida to remain on a level roughly equivalent with the rest of the Nation, since we already possess fewer resources to provide such care, and future plans envision a maintenance of this deficiency.

One of the things that we would like to recommend to you is that perhaps an amendment be made to title XXXVIII of the United States Code—and we understand that Congressman Mica has H.R. 1347 now—that would allow us to reallocate the resources available to the VA depending on demographic factors. As a result, this could alleviate the problem and allow us to bring the veteran population in Florida at least to the national average, which does not mean we are above or below but just the national average. There would be other States that would be higher than ours in available facilities.

We are concerned about the lack of State nursing or domiciliary homes for veterans. We have asked for funds and we have been told that those funds will not be available until 1986. It appears that the applications are processed not according to needs but according to the date of submission. I think that again this should be addressed as far as the allocation of veterans' funds.

For the same reason, we would note that Florida does not have access to a long-term VA psychiatric treatment facility in our State. As was noted in the previously mentioned VA study "Health Characteristics of Veterans and Non-Veterans", nearly one-quarter of all VA hospital discharges on a national basis are for this type

of treatment. We believe that the lack of such a facility for Florida represents a considerable hardship on those who require such treatment. At present, even though many mental health professionals agree that providing such treatment in the general proximity to the individual's family is beneficial, Florida must rely upon the availability of such treatment in other States, thus removing the chance of such family interaction during treatment. Although plans do exist for construction of such a facility in Florida in the future, we believe that such plans should be expedited as much as possible.

In closing, Mr. Chairman, I would like to make one other observation that has resulted from this Veterans' Commission's recent experiences. As you may already be aware, Florida has taken considerable interest in the issue of Vietnam veterans in our criminal justice system. At the request of Governor Graham and members of the Florida cabinet, our commission has been attempting to investigate the incidence of criminal behavior in veterans and also to suggest possible alternative methods of treating this problem.

One such alternative that has been proven effective and practical has been the recent commutation of such an individual's sentence in order that he could attend a specialized program for counseling offered by the Bay Pines VAMC. This was the case of Stringer, which I believe was the first in the Nation. This program is referred to as the "Vietnam Veteran Combat Unit". Although the results of such treatment would appear to be highly encouraging, the availability of entry into this program is highly restricted because of limited funding.

It would be highly beneficial to recognize this new syndrome and provide adequate funds so that we can best understand the various psychological problems that affect our Nation's combat veterans so that we can predict and cope with them effectively. Treatment and knowledge of the cause of posttraumatic stress disorder will be of great value in the future in terms of crime prevention and the restoration of an individual to be a member in good standing of our society.

In any event, we would like to suggest that you assure that adequate funding is available for such programs and that, based upon the apparent need for such indepth psychological counseling in Florida, we be considered for the establishment of another location for such treatment.

Mr. Chairman, we have heard the statistics several times. Sixteen percent of our population are veterans. Currently we estimate 1.5 million strong and growing at a rate of 5,000 per month. I'm not going to compute that per minute.

What I would like to say is our veterans have done their share and now it is time for us to do ours.

On behalf of Governor Graham, the commission and the Florida veterans, I thank you for allowing me to share these thoughts with you, sir.

[The statement of General Felices appears at p. 81.]

Mr. EDGAR. Thank you very much. I really appreciate your statement and particularly want to commend you for your comments about Vietnam veterans. Our committee spent some time sitting around the table in a rap session yesterday in the Combat Unit at

Bay Pines talking particularly to Vietnam veterans who are utilizing the 20 person unit there which is designed to treat delayed stress syndrome.

It was our committee that established the 136 readjustment counseling centers as the first step to reach out in store-front settings to Vietnam veterans. We have discovered that throughout the Nation there are presently nine combat units similar to the one at Bay Pines. We have had the privilege of visiting 2 of those 10 and it is our hope that over the next several months we will develop some legislation to see to it that centers like that are established in other places as well as some basic research done on the problem.

We were responsible for the 3-year extension of the readjustment counseling centers, which is now pending in the Senate, and which we believe will become law very shortly. In that 3-year extension is an extensive study of the Vietnam-era veteran, including the problems of women veterans, including the problems of psychiatric and drug and alcohol abuse needs, the need for employment and the other aspects of Vietnam veterans readjustment status.

I particularly appreciate your focus on prisoners. So often when someone commits a crime the rest of us in society overlook those persons. We are discovering that a number of criminals who—not condoning the actions they have taken as criminal acts—have, in fact, committed those acts while displaying some of the symptoms of delayed stress syndrome. We are discovering that in our combat units like the one at Bay Pines there are many people, who had they not found their way to such a unit, would, in fact, have had a life of crime and a life that would not be conducive to being put back into the mainstream of the public. So I appreciate your comment there.

I wonder if you might comment for us and tell us how many State veterans' homes and domiciliaries you operate as a State here in the State of Florida. Do you have any State domiciliaries?

General FELICES. We have none, sir. We have solicited—I believe the funding is something like 60 percent Federal funding and the balance is from the State. We have solicited funds for such facilities and we have been told that the earliest we can expect it is 1986.

Mr. EDGAR. So you're on the waiting list for funds for that, but you are not opposed to participating in the program.

General FELICES. Not at all.

Mr. EDGAR. For those in the audience, this is a program that we on this committee are very supportive of. The Federal Government will commit up to 65 percent of the funds for construction of a State domiciliary, a nursing home, or a hospital that would be run and operated by the State. The State would have to come up with 35 percent. They could, in fact, if the States had their own nursing home or domiciliary, renovate those facilities with that 65–35 formula. Then the Federal Government would commit itself to providing a percentage of care on a per diem basis. It was my bill in the House, which is now pending in the Senate, to increase that per diem at a fair rate so that the Federal Government's commitment would be approximately 30 percent and the State government's participation would be about 70 percent for the day-to-day costs of care of those veterans.

As Bill mentioned, we have to look at alternative ways of providing service. In the State of Pennsylvania we have two State-operated veterans' nursing home facilities and domiciliary facilities. They help to alleviate the overcrowding in the fully operated 100 percent federally funded VA programs. So I would encourage you not only to stay on the waiting list, but we are trying to dislodge OMB from its stickiness on the funds that are available to hopefully get that State sharing agreement moving so that more States can apply. There is simply a good, economical cost saving to the Federal Government to have the States participate. We would hope the State of Florida would participate in that program. We're going to try to do what we can to dislodge that backlog.

One final comment I might make to you. In our travels we discovered that the State of Florida does not have a geriatric research center. We established a new program under the guidance and leadership of a former colleague on this committee, Margaret Heckler, a program called GRECC's, Geriatric Education Research and Clinical Centers. The original intention was to have 15; only 9 have been established. These are centers to research the impact of aging on health care needs, particularly those of veterans. We think that that research will be helpful to the general population at large.

Given the statistics that you and others have outlined, I would think that working with your VA professionals here that some work over the next period of time—and I can't guarantee you the short term—that this region of the country, particularly the State of Florida, might be a conducive area for such a service. It doesn't necessarily provide any more service to those senior citizens or retirees, but it could give us some information in terms of improving the quality of health care on into the future and teaching the rest of society.

Buddy MacKay was with us the other evening in our original hearing earlier this week, and he reminded us of the book by John Naisbitt called "Megatrends", which states that Florida is to be the trend-setter. There were four States selected by John Naisbitt as the trend-setting States, because of their population pressure. As he discussed in that book about the greying of America and the aging of America, he says "Look to Florida. What's happening in Florida is going to happen in many parts of the rest of the Nation." And as Florida begins to meet its needs, the rest of the Nation ought to take a peek at that. I would suggest that that is a good thing for us to do, to look at Florida.

I would also hope that Florida would look at some of the older industrial cities and States of the Northeast and Midwest and not make the mistakes that we did.

I was going to ask you one final comment, with all this burgeoning population, is the Governor prepared to have enough clear water for all of those people? I'm nervous about whether or not you have enough drinking water. I thought of getting another glass, but I wanted to conserve it as much as possible.

General FELICES. Mr. Chairman, I can assure you the water at this airport is good, and we are constantly looking at that problem in Florida. I am sure it will be resolved.

Mr. EDGAR. It's going to be an emerging problem for you. Both John Paul and I serve on the House Public Works and Transportation Committee, and we serve on the Water Resources Subcommittee and Surface Transportation Committees. Florida has been to our committee on several occasions for some assistance in that area.

I yield to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. General Felices, we want to thank you very much for your statement and for your appearance, along with your colleagues who represent the Florida Commission on Veterans' Affairs and the Governor's views. I think the chairman has pretty well gone over the points of particular importance to us. It is too bad there is a backlog on the matching grants for State veterans nursing homes and domiciliaries. We tried to up that by about $16 million in the budget, and I think we were successful in doing that, but there is about a $60 million backlog.

I won't take any more time, we have so many witnesses, but we do want to thank you very sincerely for your appearance here today.

General FELICES. Thank you, sir.

Mr. EDGAR. Are there any other questions, Bill or Bill or Tim?

Mr. PENNY. I just wanted to find out if Florida was ready with dollars to match the Federal dollars for State nursing homes.

General FELICES. Yes, sir.

Mr. PENNY. If we could accelerate the availability of money in that program and move some of that forward so more money would be available in fiscal year 1984, would Florida be ready with matching funds to participate in that?

General FELICES. We are asking you today to look very carefully at the amendment that Representative Mica has introduced, because what we are asking is that the granting of dollars be based on need, which our need would immediately accelerate ours. While I cannot tell you that we have the money immediately, we would make the money available.

Mr. HAMMERSCHMIDT. Tim, would you yield on that point?

Mr. PENNY. Surely.

Mr. HAMMERSCHMIDT. Will they accept your application, or will they not accept it until the money becomes available?

General FELICES. The application is in Washington. They have told us that no moneys would be available until 1986.

Mr. HAMMERSCHMIDT. So it's a pending application?

General FELICES. Yes, sir.

Mr. HAMMERSCHMIDT. Thank you very much.

Mr. PENNY. This is maybe an odd question, because so much of what we're going to do for veterans has to be initiated by the Veterans' Administration at the national level. But is Florida looking at short-term options that will help meet the needs of these veterans at the State level in the absence of Federal assistance?

General FELICES. We are looking at short-term options in the area of domiciliary and nursing care homes, to see whether we have facilities available that belong to the State that can be converted, yes, sir.

Mr. EDGAR. I might mention we are also looking at military installations as an option to share some facilities. In some parts of

the country there are hospitals that are underutilized and facilities that are underutilized in the military. That may not be the case in Florida, but it is the case in some other parts of the country.

Thank you very much for your testimony.

General FELICES. Thank you, Mr. Chairman, and members of the committee.

Mr. EDGAR. Our next witness—and he will be represented by many colleagues—is Mr. Donald P. Thompson, Director of the Southeastern Region, Department of Medicine and Surgery, of the Veterans' Administration. He is joined by the Directors of the Bay Pines facility, the Gainesville facility, the Lake City facility, the Miami facility, and the Tampa facility. We ask that all the Directors of those facilities join Mr. Thompson at the table.

Mr. NELSON. Mr. Chairman, while they are being seated, I would like to acknowledge the Greater Orlando Aviation Authority in providing these facilities, specifically Jack Giluley and Norman Glass. In order to accommodate your schedule of flying in and then having to fly on to Washington, I thought that this would be a convenient location for you, that you could maximize the use of your time. Mr. Giluley and Mr. Glass honored our request with graciousness and we appreciate that very, very much.

Mr. EDGAR. Bill, I hope you will express to them our gratitude for the use of the space, and also indicate to them that, again, as John Paul and I serve on Public Works and Transportation, we have jurisdiction over aviation as well. [Laughter.]

We would be glad to talk to them on the side——

Mr. NELSON. Then we just killed two birds with one stone here today, Mr. Chairman. [Laughter.]

You can see this fine airport facility, Mr. Chairman, which we think is one of the finest in the world. We are delighted to have you here as a member of the Public Works and Transportation Committee.

Mr. EDGAR. I enjoy my service on that committee, as does John Paul. When we go out across the country on veterans hearings, it is often that we hear the need for highways, waterways, aviation, economic development, and John Paul and I get double duty.

Mr. Thompson, we are very pleased to have you here. In each of our six regional hearings, we have asked the regional director to comment, present a statement, and have asked him to be joined by the directors of his major hospital installations, where possible. It is our hope that in your statement you will feel free to cover the issues of concern to you and to be as frank as possible. Frankly, we listen in Washington to hours and hours of testimony and we hear from the central office, and occasionally some of you are represented there in the hearings. But we found, particularly in our first four of six visits, that getting out into the field we learned more than we could learn in Washington by seeing, feeling, touching, and having an opportunity to hear from people in the field as to what the specific needs are.

Sometimes, as you have to translate your information through the central office, through the Office of Management and Budget, through the administration, the message to us in Congress sometimes gets confused and garbled. So we are pleased that you are here and we look forward to hearing your statement.

The full text of your statement will be made part of the record, and your colleagues that are with you, I invite them to speak, and we will have some questions for each of them as we proceed.

STATEMENT OF DONALD B. THOMPSON, DIRECTOR, SOUTHEAST REGION, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY RICHARD F. McELLIGOTT, DIRECTOR, VA MEDICAL CENTER, BAY PINES, FLA.; RICHARD WHITTINGTON, M.D., ACTING DIRECTOR AND CHIEF OF STAFF, VA MEDICAL CENTER, GAINESVILLE, FLA.; HOWARD M. RUPPEN, DIRECTOR, VA MEDICAL CENTER, LAKE CITY, FLA.; THOMAS C. DOHERTY, DIRECTOR, VA MEDICAL CENTER, MIAMI, FLA.; AND JOHN T. RIGGIN, JR., M.D., CHIEF OF STAFF, JAMES A. HALEY VA HOSPITAL, TAMPA, FLA.

Mr. THOMPSON. Thank you, Mr. Chairman.

Mr. Chairman, before beginning my statement, I would like to introduce the officials of the various Florida facilities that are here with me today. Representing VAMC Bay Pines and the Fort Myers Clinic is Mr. Richard F. McElligott, the director of the facility. Representing Gainesville and the Jacksonville Clinic is Dr. Richard Whittington, the chief of staff and acting director at Gainesville. Representing VAMC Lake City, Mr. Howard Ruppen, the director. Representing Miami, the Oakland Park and Riviera Beach Clinics, Mr. Tom Doherty, who is also serving today as the acting medical district director. Representing Tampa is Dr. John Riggin, the chief of staff.

We have also in the audience, in case questions are directed his way, Dr. Charles Silverblatt, who is the Director of our Orlando Outpatient Clinic.

Mr. Chairman and members of the subcommittee, we really appreciate having you join us today in Medical District 12 to discuss the provision of health care services to eligible veterans in the State of Florida. I am pleased to have the opportunity to provide you with this overview and to respond to any questions you may wish to pose.

The primary mission of every VA medical center is to provide the highest possible quality of health care services to our Nation's veterans in a cost-effective environment. We in the southeast region and in Florida are firmly committed to this mission.

In Florida, we provide care through a network of facilities in Medical Districts 10 and 12. District 12 serves peninsular Florida, including the five hospitals whose directors were just introduced, plus five outpatient clinics in Jacksonville, Orlando, Fort Myers, Riviera Beach, and Oakland Park. These facilities provide care to veterans residing in 59 Florida counties and 19 counties of south Georgia. The eight counties of the Florida Panhandle are served by the medical centers at Biloxi, Miss. and Montgomery and Tuskegee in Ala., and through a small outpatient clinic located at Mobile, Ala.

In addition to the existing facilities, satellite clinics have been approved for Pensacola and for Daytona Beach. These are planned for activation during the summer of 1985. Further, the Administrator of Veterans' Affairs has recommended to Congress, as we have

heard here this morning, through the fiscal years 1984–1988, 5-year facility construction needs assessment, that a new medical facility be planned for Palm Beach County to meet the increasing demand for services in the south Florida area. If approved and authorized by Congress, construction of that facility should begin in 1988.

The facilities serving Florida veterans provide a full range of primary, secondary, and tertiary care that compares, in my opinion, favorably in quality to that found anywhere in the health care industry, private or public sector. They are affiliated with three medical schools in Florida and represent urban, rural, large and small acute and long-term care facilities.

The major deficiency in facilities at this time is the lack of a long-term neuropsychiatric care facility. However, present planning calls for the construction of a 290-bed addition at Gainesville to provide this service. The present 5-year construction plan shows that construction would begin in 1987. In the interim, the long-term care for psychiatric conditions is being met largely through the fee medical and contract hospital programs within the State. For this reason, Florida ranks fourth highest in the Nation in the use of fee basis and contract hospitalization.

Currently the Veterans' Administration is authorized to operate 3,019 hospital beds and 520 nursing home beds to serve the needs of Florida veterans. Our centers and clinics employ 7,703 full-time equivalent employees and their combined budgets for fiscal year 1983 totaled more than $317 million. In addition, the Florida medical centers have $6,185,284 in VA-funded research, including significant initiatives in medical research, rehabilitation, agent orange, and health services research.

The 7,703 full-time equivalent employees include 1,318 FTEE registered nurses and 416 FTEE physicians. Our medical school affiliates increase our physician staffing levels by 186 FTEE who serve as house officers. The Florida facilities are fortunate at this time to have minimized nurse recruitment and retention concerns. Presently there is a total of only 26 nurse vacancies existing within the district.

This fiscal year, the medical centers will accomplish projects totaling $6,468,000 in the nonrecurring maintenance and repair program. In addition, they received $2,255,000 in jobs bill funding to support another 24 projects in the State.

Presently there is an estimated 1,442,240 veteran population residing in Florida. According to our statistics, 5.1 percent of these veterans are women; 1.8 percent of the total saw service during World War I, 46 percent from World War II, and 27 percent are Vietnam veterans. Of interest is the fact that the oldest surviving veteran of the Spanish American War is a resident at the Bay Pines nursing home care unit.

At present, 25.5 percent of the veteran population are over 65 years of age, and by 1990 that percentage is expected to increase to 41.2 percent. The veteran population for the State is expected to continue increasing, peaking by the year 2000, after which it is expected to decline slowly to about 1,280,000 by the year 2010.

The Florida veterans are availing themselves of our services. During fiscal year 1983, we expect to treat 70,627 inpatients and to record 873,355 outpatient visits. Applications for medical care are

expected to total 165,789, exceeding last year's level by 7.1 percent. The percentage of veterans who are service-connected, as opposed to nonservice connected, receiving outpatient care has increased to 68 percent, ranking Medical District 12 first in having the highest percentage of service-connected veterans in the Nation.

Workload and productivity measures show the Florida medical centers are among the most active in the system. Overall, hospitals are maintaining an occupancy rate of approximately 80 percent. Outpatient workloads are exceeding plan by 6.7 percent. Each medical center has appointed a physician coordinator for the prisoner of war assessment program and each is processing agent orange examinations on a current, timely basis.

Fiscal year 1982 was the first year of the Department of Medicine and Surgery's Medical District Initiated Planning Process [MEDIPP], which, of course, is a grass roots population based planning program to assess the health care needs of veterans. The first plans were completed in November 1982, and projected district needs through 1990. The MEDIPP plan for Medical District 12 indicates a 15.7 percent increase in the number of veterans in the district from 1980 to 1990, and projects a dramatic 169-percent increase in veterans over the age of 65 during the same period. These data point out the imperative to meet the needs of our aging veterans by providing planning for additional nursing home care beds and promoting the development of noninstitutional innovations such as adult day care centers, hospital based home care programs, and residential care as alternatives to inpatient bed care.

During fiscal year 1982 Medical District 12 completed a congressionally mandated 30-year study of veteran health care needs in Florida which identified a need for 1,251 additional hospital beds to care for the veteran population which is expected to continue to grow over the next 17 years. Two-hundred and forty two of these needed beds have been identified as long-term psychiatric and sited for Gainesville and Miami. A recent study was also undertaken to determine potential sites for the remaining beds. This study, which contemplated the suppressed demand at existing facilities modified the total bed need upward to approximately 1,500. As a result of this study, a facility of 625 beds in Palm Beach County was identified as the priority site.

Medical District 12 has also developed plans to meet the nursing home needs for 1990. The plans are as follows: 120-bed nursing home care units at Tampa and Lake City are currently under construction, and second units at Miami, Gainesville, Tampa and Lake City in the out-years. The projects for Tampa and Lake City and the 1984 project for Miami are approved and funded. The second addition at Tampa, Lake City, and Gainesville are approved but not yet funded. When completed, at a cost of approximately $51.4 million, 680 beds will be added to the existing 520, bringing the district total to 1,200 nursing home care beds. Further nursing home needs will be met by encouraging the State of Florida to construct a State nursing home facility and by contracting for an additional 900 beds in the community nursing homes program. Medical facilities in Florida now contract for 526 community nursing home beds.

The hospital facilities in Florida have been or are in the process of being upgraded. A list of the construction programs is attached

to my full text statement.[1] The 19 projects listed there total approximately $531 million in construction expenditures. Because of Tampa's growth and limited space for expansion, the medical center must acquire additional land to accommodate their facilities and parking. The intent is to purchase somewhere between 16 and 20 acres of land immediately adjacent to that facility.

Since 1974 there has been a 47-percent increase in the number of inpatients treated and a 74-percent increase in outpatients treated in Florida. In recent years, however, it has been necessary to limit access to care on the basis of eligibility priority groups. Consequently, the percentage of service-connected veterans treated as outpatients has risen 36 percent since 1980. The Nation as a whole has experienced only a 2-percent increase in the percentage of service-connected outpatients treated.

The priority of service-connected veterans has clearly received emphasis in Florida facilities. Medical District 12 has the Nation's highest percentage of service-connected outpatients treated and ranks second in percentage of veterans applying for hospital care for service-connected conditions.

In an effort to relieve deficiencies, I have made funding adjustments within the southeast region in fiscal years 1982, 1983, and 1984, which will total $22.2 million and 252 full-time equivalent employees. Of these full-time equivalent employees, approximately 120 were nurses. These adjustments have provided some small relief. The Department of Medicine and Surgery is currently developing a resource reallocation system which will shift resources over a period of 3 to 5 years to areas of increasing demand from areas of declining workloads. Current plans call for the implementation of this program in the fiscal year 1985 budget.

Other activities are being implemented to improve efficiency in operations and improve our ability to respond to patient care needs. An example of such a program is our decentralized hospital computer program in which every medical center will receive computers, beginning some time after January 1984, to handle core functions of patient admissions, transfers and discharges, and pharmacy. Further applications will be implemented later in fiscal years 1984 and 1985, giving the district automated data processing capability never before available in the Veterans' Administration. We thank the members of the committee for their efforts on our behalf in providing these very vital services.

Mr. Chairman, this concludes my formal remarks. I wish to express again the appreciation to the subcommittee for the opportunity to discuss Florida's needs. My colleagues and I stand ready to answer any questions that you may wish to pose.

[The statement of Donald B. Thompson appears at p. 85.]

Mr. EDGAR. Thank you, Mr. Thompson. I have about a zillion questions to ask, and I am going to yield to my colleagues before I get into my questions. So, I will yield first to John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Thompson, and the hospital directors with you, your percentage of service-connected patients is very high as compared to na-

[1] See p. 93.

tional averages. Does this mean that you are turning away an abnormal number of non-service-connected cases and, if so, shouldn't your total resources be redistributed more quickly than indicated by your testimony?

Mr. THOMPSON. The answer to that, obviously, sir, is that we are being forced to be very restrictive in the provision of services to the non-service-connected veterans. We are making every effort at this present time to reallocate resources.

The 1985 budget process begins for us in January, with the issuances of the target allowances. So we are really talking about an October 1, 1984, implementation date.

Mr. HAMMERSCHMIDT. You think, though, it would take 3 to 5 years to do that reallocation?

Mr. THOMPSON. Simply because of the impact of the redistribution of funds from other facilities to those facilities with greater need, it would have to be on a phased basis.

Mr. HAMMERSCHMIDT. You just don't think there is that much slack out there that you could move quickly on?

Mr. THOMPSON. No, Congressman.

The situation is essentially this: The resources aren't plentiful anywhere, and as we have a decline in workload in one place, there is usually, through a liberalization of the admission policies at that facility, an ability to bring more people in. There will probably never be enough resources to totally meet the demands of everyone. We're stuck here with a situation of relative funding. We are relatively less well funded than other areas of the country.

Mr. HAMMERSCHMIDT. How is your actual workload as compared to your projections, and have you had to curtail the purchasing of equipment or curtail any maintenance or repair projects?

Mr. THOMPSON. There have been funds that would be normally obligated for use in purchasing equipment and to provide M&R projects that have, indeed, been diverted for use for recurring purposes, such as providing care.

Mr. HAMMERSCHMIDT. Does the VA medical budget procedure take into account the veteran visitors that come into Florida and need hospitalization, and if it does, please explain how that is taken into account.

Mr. THOMPSON. In a sense, the funding of workloads is traditionally based on historical data. Veterans who come to Florida and receive care in a Florida facility, regardless of where their home of origin is, do get counted in the overall workloads. For example, if a given facility is treating 80,000 Florida veterans and 20,000 from other localities, the full count that goes in for funding purposes is the 100,000.

The problem in Florida, as I say, is really more the influx of new people who are here as permanent residents rather than people who come down on a temporary basis. Our indication is that only approximately 2 percent of our inpatient workload is temporary residents or transients.

It is very difficult to see in terms of outpatients, because we do not keep statistics on the basis of origin in our outpatient program. But they are at least partially compensated for in our funding system.

Mr. HAMMERSCHMIDT. Is the VA system tied together with computers to keep track of these transient people that move back and forth?

Mr. THOMPSON. No, Congressman, not at this point. This would be one of the future applications we would hope of the decentralized computer system. But at this point in time we do not have that capability available to us.

Mr. EDGAR. Would the gentleman yield?

Mr. HAMMERSCHMIDT. I yield to the chairman.

Mr. EDGAR. I am struck with that answer, because it seems to me that, given the pressure that we have heard about here in Florida, of the in-migration and flux and change over the seasons, it would seem to me that would be helpful to your administrators to have some information quickly at their fingertips.

I have two questions. One, when do you think that capability will be available in terms of real time, and second, the question relates slightly differently, do you keep accurate records of those patients who are turned away from health care facilities in the region because of lack of resources?

Mr. THOMPSON. Mr. Chairman, I would have to answer that no, we do not keep accurate records. We keep only a percentile record. We know the percentage of acceptance into our programs.

To answer the first part as to when this might be implemented, one of the basic core elements is our admission, transfer, and discharge data system that will give us a much better handle on the applications, where the people are coming from, what conditions they are presenting, and what disposition is made. So we will get, in our very early implementation of the computer system, some data to that effect. At the present time we just do not have that data available to us because all data, in all VA facilities at this time is essentially hand-gathered data. The people that it would take to do this are busy working at the desk, receiving the patients and hopefully giving them the type of service that they deserve.

Mr. HAMMERSCHMIDT. As you know, we have had this ongoing discussion about computer services in the VA, and now that that has been resolved, I am assuming this will help expedite the decisionmaking process.

Mr. THOMPSON. No doubt that it will, Congressman.

Mr. HAMMERSCHMIDT. We have had the pleasure, as you know, of being with two of your directors while we have been in Florida, Mr. McElligott and Mr. Doherty. Some of these questions we pursued with them informally, but now that we're on the record we need to get the responses for the record.

So let me ask you: What kind of sharing is taking place or planned in light of Public Law 97-174, the VA-Department of Defense sharing law?

Mr. THOMPSON. I don't believe I can answer that specifically at this time.

Mr. HAMMERSCHMIDT. Do you have a director that might want to respond?

Dr. WHITTINGTON. I can speak to that.

We are in the very early stages now of trying to set up relations between the Gainesville Hospital, the Jacksonville Outpatient Clinic, and the Jacksonville Naval Hospital. The VA has given us

our implementing guidelines. The hold up has been the Department of Defense not giving such guidelines to the military hospitals. But we are actively interested—and I am sure the other directors can speak to the point, too, of what is going on in their facilities.

Dr. RIGGIN. For Tampa, we have been in contact with the hospital commander and his staff at the McDill Air Base since last December and have formulated some tentative clinical areas wherein they have indicated they have need. In turn, the corresponding clinical sections in our hospital are looking at the possibility of how to provide that need.

To a considerable extent, one of our problems is the recurring problem that we already have, and that is, it takes more personnel, more equipment, more supplies, in order to get that program started. But we are in active contact with MacDill at the present time.

Mr. HAMMERSCHMIDT. I noticed our colleague, Mr. McCollum, suggested there may, indeed, be a shortage of personnel in the military hospitals and their establishments, and therefore that may impede the mergers that we would hope could take place there in a joint sharing of care.

Mr. EDGAR. Would my colleague yield?

Mr. HAMMERSCHMIDT. I yield to the chairman.

Mr. EDGAR. I wonder, also, in your answer if you could be as specific as possible in terms of what is it that you're going to share—laundry facilities, medical facilities, CAT scanners, dialysis machines, surgeons? What are some of the discussions in terms of what, in fact, might be shared with the military?

Dr. RIGGIN. Mr. Chairman, I was referring specifically to clinical activities. This would be, for example, the provision of CAT scan studies, nuclear medicine studies, cardiology evaluations with all of the attendant examinations that goes on there. We do find that MacDill, on the other side of the coin, does have a capability in gynecological procedures. We can provide outpatient work; if we have to, we can provide inpatient care, but MacDill is set up so that they can do that even better for us.

Gastroenterology has been identified as an area where specifically they would like for us to carry out certain examinations. Our contacts have been addressed to specific clinical requirements that MacDill has.

Dr. WHITTINGTON. I might add for Gainesville our discussions have been very much in the same vein. In addition, however, we have said that we could take acute neurosurgical injuries—for example, head injuries—which they now have to send to a civilian hospital in Jacksonville. We feel we could provide better care, and it would probably be more reasonable, also, as well as doing the CA scans and so on.

On the other hand, with our Jacksonville clinic, we could use some gynecological support, which Dr. Riggin referred to, and also they have dermatology support which we don't have there. So there are very real areas where it would be mutually beneficial and in total save the taxpayers money.

Mr. HAMMERSCHMIDT. Gentlemen, I won't pursue this any more in my questioning, except if each of you hospital directors or Mr. Thompson would want to compile for the record the extent you are

involved with the military and cost-sharing, a brief summary of it for our record, I think it would be very helpful, since it is a fairly new program and we would like to see it get activated.

[Subsequently, the VA furinished the following information:]

In response of Mr. Hammerschmidt's question regarding the extent we are involved with the military and cost-sharing, the following information is provided: Although a formalized sharing agreement has not yet been established, the Orlando Outpatient Clinic does have a working agreement with the Orlando Regional Naval Training Center; we provide cardiac pacemaker monitoring for them and they provide mammography services for us. Presently, the VAMC Tampa is working on an agreement with MacDill Air Force Base and the VAMC Gainesville is working on an agreement with the Jacksonville Naval Air Station.

Dr. WHITTINGTON. Mr. Hammerschmidt, there is one other thing that I think should be mentioned in relation to the medical district planning. We did look at the possibility of this surplus DOD bed availability that we might use in lieu of construction of VA beds, either take over a portion of the beds or a whole hospital or whatever. We looked at the Jacksonville Naval Hospital and we also looked at the Pensacola Naval Hospital. We were quite surprised because the authorized bed levels for both showed at about 350, in that ball park. Yet, when we went to the hospitals, they had a census of 115 to 120. But that hospital was full. The authorized bed levels in the military are set for wartime situations, where you put beds in the mess hall and in the halls and so on. So our findings to date are that in Florida there are no surplus DOD beds that we have been able to identify as yet, but we are continuing to look at that.

Mr. HAMMERSCHMIDT. Interestingly enough, just as an aside, we were in the Chicago area and we found just the opposite to be true——

Dr. WHITTINGTON. Right.

Mr. HAMMERSCHMIDT [continuing]. In the naval hospital up there.

Dr. WHITTINGTON. We haven't looked at all the military hospitals in Florida, but the two we looked at, where we thought we could use them, they were of no help.

Mr. EDGAR. Would the gentleman yield?

Mr. HAMMERSCHMIDT. I yield.

Mr. EDGAR. I wonder if you might speculate I noticed that as well when we visited some of the military installations, that they have *x*-number of beds on paper and stored upstairs and ready to go in time of conflict. I realize the need to be prepared for that kind of conflict, but it just struck me, in looking at some of the equipment and some of the areas set aside, that if we really get into a future war, whether or not those spaces are going to be, frankly, adequate. It would seem to me much more appropriate to have a working staff of nurses and physicians caring for veterans and caring for as many, particularly here, of the nonservice connected veterans that may, in fact, be turned away in others, and in a time of crisis to begin to phase down the services there and phase up the services for military needs. To sit around and wait for World War III, although with recent news events there is a concern for all of us, it seems to me to be a waste of the opportunity to have staff and professionals on duty.

When I asked the military people in Chicago how practical it is that overnight you're going to fill up those beds, they said, "Well, look, we could fill them up with people in an emergency but we wouldn't have anybody standing next to those people in terms of nurses and technicians and others." I just think we maybe ought to really confront the military people as to whether or not that is a sound policy, given the 1980's and 1990's philosophy, to sit around with hundreds of beds on their census record not being used when, in fact, we have got the need for those beds clearly in the veterans' area.

Mr. HAMMERSCHMIDT. Mr. Chairman, I just have one more question and then I will yield to my colleagues.

We sometimes hear complaints from veterans that the VA is no longer providing medication for non-service-connected conditions, even though it has been previously provided for long periods of time following hospitalization. I wonder if you would comment on this situation as it pertains to your medical district in Florida.

Dr. WHITTINGTON. I could tell you what's happening—and it's a justifiable complaint of the veterans—but specifically at Gainesville the law or VA regulations state that a patient who is hospitalized could be followed for up to a year. In essence, we didn't pay any attention to it. We would keep a veteran on for as long as we felt it was medically necessary and people with chronic illnesses stayed on for a long time. But when the pinch came—incidentally, the pinch on getting care in Florida is much greater in getting outpatient care than it is in getting inpatient care. For inpatient care, the big crunch is for the psychiatric patient. This last 3 weeks we have sent at least one or two patients a week down to Tampa because there are no beds in north Florida for psychiatric patients.

What has happened is, as we got constrained and only had so much room and so many people—we stayed at the level at our hospital, for example, of about 100,000 outpatient visits. When more and more people came, the ones with higher eligibility got taken care of and the ones who really did not meet the requirements or the guidelines in the regulations, were dropped off the program. A fellow with high blood pressure still had his high blood pressure, and it was controlled with medication. Yet we had to drop him. We would get a social worker to talk to him and refer him elsewhere. But often these institutions wouldn't take care of these veterans or the veterans simply didn't seek this care outside the VA. So it is a very justifiable complaint, but it is totally the result of a demand exceeding our capability to accommodate it.

I think the key figure that our planning board came up with is that in the State of Florida 75 percent of the people that we see as outpatients are service connected. So that leaves only 25 percent for the nonservice connected on a space available basis, whereas nationwide that is 50 percent. So that's where the crunch is. That's where we are hurting.

Mr. HAMMERSCHMIDT. I believe the Miami Director told me his figure was up to 84 or 86 percent——

Dr. WHITTINGTON. Yes, they're going up. My figure is a year old. And he's worse off than we are.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. Thank you, gentlemen.

Mr. EDGAR. Mr. Penny?

Mr. PENNY. I was simply going to ask for percentages for each hospital, those that are——

Mr. THOMPSON. The percentage of service-connected?

Mr. PENNY. Yes.

Dr. WHITTINGTON. The nondiscretionary—do you have those?

Mr. PENNY. You indicated you didn't have a head count but you had percentages. I was wondering if you could give those for each.

Mr. THOMPSON. This would be the acceptance rate of the applications. So far in 1983, and projected to the end of this month, we expect to receive 165,788 applications; 142,000 will be found in need of care, which is about an 85.7-percent acceptance rate.

Dr. WHITTINGTON. But what Mr. Penny wanted to know, I think, was the percentage of service connected at each hospital.

Mr. PENNY. Yes.

Dr. WHITTINGTON. In general, it is the highest in the South, in Miami, and it is probably fairly similar at the rest of the hospitals, I expect.

Mr. PENNY. You said the percentage statewide was 75–25?

Dr. WHITTINGTON. Statewide is 75–25. It would be higher in Miami and probably slightly below, 70 or 72 percent in the other four hospitals. They would be pretty close, I think.

Mr. THOMPSON. This is the nondiscretionary workload.

Dr. WHITTINGTON. Yes. Here we're talking about the outpatient nondiscretionary workload.

Mr. THOMPSON. The service connected workload statewide is 68 percent, which is the highest in the Nation, looking only at those people who are entirely service connected.

[Subsequently, the VA furnished the following information:]

The percentage of service-connected outpatient visits for each of the hospitals is the following: Bay Pines 75; Gainesville 59; Lake City 43; Miami 69; and Tampa 69.

Dr. WHITTINGTON. That's service connected, plus World War I, plus those in receipt of aid in attendance and so on that we're required to follow, the 1010's.

Mr. PENNY. No other questions.

Mr. EDGAR. Congressman McCollum.

Mr. MCCOLLUM. Thank you, Mr. Chairman.

I just have one or two questions, but before I do that, I want to compliment the folks at the Tampa and the Bay Pines hospitals, because when my old district went all the way to Clearwater Beach, we had some specific requests related to outpatient statistics and they went out of their way to help my staff gather that data, which you don't routinely do. So I think you should be aware that we have some mighty fine folks willing to go a little extra down here for that sort of thing. If the committee needs it, I am sure you would be willing to provide it like you did to us.

I would say, in asking a question and following up on this outpatient thing, that one of the things that came to light during that period of representation—and I think you just got an earful of that sort of thing over in Mr. Bilirakis' district here recently, in that area——

Mr. EDGAR. I remember it.

[Laughter.]

Mr. MCCOLLUM. Well, that used to be my territory where you heard that.

Some efforts were being made last year and the year before and so on to pilot and direct some resources to some mobile vans in outpatient areas in some regions in the country.

Has anything further been done on this? Are we looking at that in this region here? I haven't been attuned to that in the last 6 months or so.

Mr. THOMPSON. No, sir. At the present time there is nothing going on in this regard in the region. Again, to be region-initiated, it takes resources from existing facilities. We haven't felt we have had the capability of doing that.

It has been done on a limited scale for post-hospital care follow-up, I believe out in the medical district that is housed in Salt Lake City, and there may be one or two isolated other places. But we have not at this point——

Mr. MCCOLLUM. Here in Orlando now, in my new district, are blessed with a fine operating outpatient clinic. We appreciate the attention it is getting and hope that the upgrading of it, which we know is in progress now, continues. But I know from experience that that is not true everywhere. I certainly hope this committee can help urge the others that have more of a handle on the funding to look into the mobile van concept.

Dr. WHITTINGTON. Mr. McCollum, we are going to look at that. The district planning board has selected that as one of the things to look at next year specifically, the remote veteran and the van concept and so on. Our staff has gotten some initial information on the cost of vans and so on. So we are in the very early stages of planning. Again, we will have a recommendation of some sort about a year from now.

Mr. MCCOLLUM. Thank you. I am glad to hear that you're doing that.

Dr. WHITTINGTON. We're thinking. We're thinking.

Mr. MCCOLLUM. Let me ask one question that is somewhat rhetorical but I think is pretty obvious, but yet I want to drive home a point with it. You have discussed at some length with us and emphasized a point that I was making in my opening comments with my colleagues, that the service-connected forces at play here are really bringing a great crunch on the nonservice-connected veterans' opportunities to get into the system.

If the projections for population growth in Florida are significantly greater than the base figures used by the study—which I know didn't have the benefit of the latest figures in this morning's paper that the Government's other arms are out there gathering—but if those are re-evaluated, as they may well be in light of these new other studies on base figures, won't that mean that even with all the new facilities that we are hoping to get through the district medical plan, that we're going to have an even greater crunch than you think you are? I mean, if those figures are significantly off in projected veteran population growth in the next 15 years.

Mr. THOMPSON. I would think that that is true, Congressman. But by the same token, we have to recognize the MEDIPP process is a constantly fluid, moving, dynamic process. I should have said at the beginning of the meeting, that Dr. Whittington has a wealth

of information because he is the chairman of the district planning board. But they are addressing this.

We have concerns about our statistical data ourselves. What we are using right now is the 1980 census data, modified to March of 1983. We know there are obvious flaws in it. It happens to be the best that we have at this time. But I assure you we will be looking at these data on a continuing basis, and every time there is an opportunity to make an adjustment in our plans and to request more funding, we will take that opportunity.

Mr. MCCOLLUM. We appreciate your handicap. I know my colleagues in Florida and I particularly do. Any way we could assist you as you go through these modifications—it doesn't have to be over site selection; we would be happy to assist you in other ways. I would welcome the opportunity.

Thank you, Mr. Chairman. I appreciate the opportunity and yield back.

Mr. EDGAR. I yield to my colleague, Bill Nelson.

Mr. NELSON. Mr. Chairman, I just have one question.

In the fulfilling and the realization of the 30-year plan as it was announced, and more recently still with regard to hospital beds in the recent report identifying the need for four hospitals in Florida, if that is accomplished by 1995, will we be able to treat the nonservice-connected disabled, or will we still be in a situation by 1995 whereby we can really only give attention to the service-connected disabled?

Mr. THOMPSON. There would have to be a significant influx in operational funding. The facilities themselves will not guarantee that the nonservice connected persons' access would improve. However, the resource reallocation system, which is based on the pace of the facilities, the quality of care, the diagnostic-related groups, things of that nature, will make a significant reapportionment that we can use as the basis for accumulating more resources.

But specifically in answer to your question, the advent of facilities themselves would not guarantee a change in accessibility.

Mr. PENNY. Mr. Chairman, may I ask a question on that same subject?

Mr. EDGAR. I yield to the gentleman.

Mr. PENNY. Have you submitted to Congress at any time in the past, or to Mr. Walters in Washington, either a request or documentation identifying how much money you would need in medical care funding to reach the same percentage of nonservice-related care as the rest of the Nation?

Mr. THOMPSON. We did at one time, approximately 2 years ago. The figure was estimated at approximately $19 million.

Mr. PENNY. $19 million was the annual figure?

Mr. THOMPSON. Yes. Now, that——

Mr. PENNY. That was 2 years ago. Would that be increased as a result of the more recent estimate of veteran populations?

Mr. THOMPSON. I would presume so. It was based entirely on a leveling of access based on service-connected and nonservice-connected. We are not so certain that that is the best way to go about it. As I say, the resource allocation system that is contemplated right now takes that among many other factors into consideration. Unfortunately, I am not well enough versed on the technicalities of

the system to get into the details of it. But early projections would show a rather large influx of dollars into the Southeastern region.

In all of the regions being typically called the Sunbelt, we do experience some pressures that are not found in other portions of the country.

Mr. PENNY. Thank you.

Mr. EDGAR. Are there any other questions before I get into my zillion questions?

VOICE IN AUDIENCE. Begging your pardon, sir, Dr. Silverblatt, who heads the Orlando——

Mr. EDGAR. Excuse me——

VOICE IN AUDIENCE. He is standing over in the corner and hasn't been recognized. I think the gentleman has paid his way in and I think he should be heard, too.

Mr. EDGAR. Excuse me. He was recognized——

VOICE IN AUDIENCE. Only by name, sir, only in name. I think the man has some input to put in.

Mr. EDGAR. I appreciate that. We have a number of people in the audience who are very capable and have some input. I want to assure everybody in the room that you can give a statement, but I would appreciate if we could work in an orderly fashion. We do have a number of questions we need to raise and we appreciate the expertise that is here. We hope to hear from that expertise. If we have specific questions that cannot be answered by our panel, we invite them to refer to others in the audience who could, in fact, answer those questions.

We also anticipate that there will be an opportunity for people to submit for the record. He was, in fact, recognized and we will move to him if we have questions.

Mr. Thompson, I am going to ask you a question which may sound a bit silly, but it is one that I am particularly interested in, and that is, what is a regional director, what does he do, and, in 25 words or less, what is his job?

Mr. THOMPSON. I would hope that he is a facilitator, a mover, a person who does everything he can to make that which is professionally sound and necessary, in the field, administratively possible.

Without getting into a great deal of detail, I attempt to help the facilities acquire the resources that they need, to attempt to move the resources within the area of my capabilities, to see to it that they are placed where we get the most "bang for our buck" in the popular vernacular, and to try assist them in any way I can in their dealings with the central office elements. I am sort of a layer imposed between our central office and the field, hopefully representing the needs of the field.

Mr. EDGAR. Do you see your role as a "cheerleader" for your medical directors and outpatient clinics with the central office in Washington? How do you envision that?

Mr. THOMPSON. I think it is really more important than the cheer-leader role. I have significant input in the central office policy formulation.

Mr. EDGAR. How often do you get to visit the facilities in your particular region?

Mr. THOMPSON. I have been the regional director now for 21 months, I guess it is, and I visit every facility at least—I think every facility now has been visited three times in that period of time.

Mr. EDGAR. What is the size of your staff?

Mr. THOMPSON. I have a nine-man staff.

Mr. EDGAR. A nine-person staff?

Mr. THOMPSON. Yes, sir.

Mr. EDGAR. Where are they located?

Mr. THOMPSON. I have six people in Washington and three in Gainesville, Fla. We came to Florida out of our concern for the pressures here in the State, to try to be closer at hand to deal with the problems that arise here in this area.

Mr. EDGAR. Why would a regional director have his staff in Washington?

Mr. THOMPSON. Simply because there are day-to-day operational things in which there must be a face-to-face interaction with the program people in Washington. It is very easy for people in Washington to make decisions based on the parameters that they see, rather than hearing the interests of the field. I try to present those and my staff tries to present those on a face-to-face basis.

Mr. EDGAR. Do all of the regional directors have their offices in Washington?

Mr. THOMPSON. All regional directors have a field office and a Washington office, yes, sir.

Mr. EDGAR. Let me ask you a specific question as a result of our tour: Why would you open a new hospital in Bay Pines without having a CAT scanner located in that brand new facility?

Mr. THOMPSON. The Veterans' Administration has had a difficult time with CAT scanners over the years. We have been playing catch up. There are some other innovative, brand new types of equipment in Bay Pines that don't exist in all the VA facilities. The prioritization of needed CAT scanners has been done purely on a professional basis in our central office element, with help from all the rest of us. This region, for example, I think now has 13 with 3 more in procurement, whereas 3 years ago we were just beginning in CAT scanning. In fact, there have been 26 purchased nationally this year, to give you an idea of the volume we have had to purchase to catch up. We still do not have all facilities with CAT scan capability.

Mr. EDGAR. I raise that question because when you see the Bay Pines facility it is a beautiful facility, well done. We didn't make the mistakes in that facility that we made in a lot of other facilities. It is highly computerized. It is attracting medical professionals from around the country.

Sometimes it is difficult to staff hospitals, given the limitation on salaries, such as Bay Pines. It is just inconceivable to me that we in the veterans area would not have opened the doors of that hospital with at least that piece of equipment in place.

I have a personal interest in that particular piece of equipment because I had a personal experience with my father who needed access to that kind of a machine, and the distance he had to travel to a neighboring hospital was not even a quarter of the distance that patients in the Bay Pines area have to travel. He was left on a

table awaiting entrance into a room, with large transportation costs, with ambulance service that left him there. It was about an 8-hour round trip for a very severely ill patient.

I just think that if you're making a shopping list for priorities, from the discussions I have had with medical people, at least that is a tool that is a state-of-the-art that we ought to encourage in our facilities.

Mr. THOMPSON. It is fast becoming the state-of-the-art. All our tertiary care facilities in the region are now equipped with CAT scanners. Both Biloxi and Bay Pines are on the current list for consideration in the coming year.

Mr. EDGAR. Do you have whole body scanners in your facilities?

Mr. THOMPSON. Yes, sir, we do have.

Mr. EDGAR. Which facilities do not have whole body scanners?

Mr. THOMPSON. Bay Pines and Lake City are two that do not. All of ours that are being purchased this year are the full body.

Mr. EDGAR. Let me ask you individually—and I would like to move from the Regional Director to the individual Hospital Directors at this point. One of the things we are interested in is innovation. We have outlined and you have outlined the emerging population; you have outlined how much is going to be spent. I added up the total dollars that are committed through 1988 to this particular area of Florida and I come up with about $530 million of construction commitments on the shopping list. That doesn't include the hospital projected in this area that we talked about. So the Federal Government, with limited resources, is making a substantial commitment to construction.

Even with spending a half-a-billion dollars, if we doubled or tripled that amount, we might not be able to meet the real needs of this particular medical region. So we are looking for other ways to help the veteran both in terms of quality and quantity of care.

Now, I know all of you are familiar with outpatient clinics—and we visited one this morning in the Palm Beach area—and Mr. Doherty was able to be with us at that facility. Each of you as Hospital Directors have outpatient clinics that you operate.

I wonder if you might comment on two things—first, what additional ways could the Veterans' Administration, if it used its imagination, service the needs of veterans, many of whom you're turning away, short of construction of new facilities, and second, if you might comment on a proposal that is being made throughout the country to locate outpatient clinics near or next to community hospitals, where possible, so that the opportunity would not only be to provide outpatient services, but also to use the technical resources of a community hospital as backup to that outpatient clinic to lessen the need for those patients going to the acute or tertiary care facilities that you operate.

Would members of the panel wish to comment on that?

Mr. MCELLIGOTT. Why don't I start from Bay Pines.

I think the first part of your question, Mr. Edgar, the areas that I see would have to do with alternatives to inpatient care. I think that the VA has to find a way to provide treatment to veterans not necessarily in an institutional setting. This might be done through better use of community resources, much as you mention with the second part of your question. It might be done with utilizing our

facilities in a different way than we presently utilize them. It might mean more of the vans, that concept that we talked about, the traveling vans to provide some follow-up services to veterans in outlying areas. And I think also it might include a better use, if you will, of the fee-basis program, which is authorized within the VA system, whereby eligible veterans receive treatment from private providers of care, which is paid for by the VA.

In the State of Florida, we at Bay Pines manage the fee-basis program for the entire State. I think that could be a cost-effective alternative to building more and more VA facilities around the State of Florida.

Mr. EDGAR. What is the annual cost of the fee-basis service for the State of Florida, in a guess?

Mr. MCELLIGOTT. In a guess, $20 million.

Mr. EDGAR. There has been complaints about fee basis by some, but it seems to me that we are really talking about a fairly good program if, in fact, the quality of care can be maintained in that fee basis, if, in fact, the location of veterans' facilities is not available to the veteran.

Mr. MCELLIGOTT. That's correct.

Mr. NELSON. Would the chairman yield on that point?

Mr. EDGAR. I yield to the gentleman.

Mr. NELSON. Could you share with this member, Mr. chairman—and perhaps the witnesses—our responsibility at looking at what is the most effective priority service for veterans and the cost of it. On a contract basis, on a VA hospital health care system basis, do we have any statistics that compare those two systems?

Mr. EDGAR. Let me just say a couple of things—and maybe the panel would like to react—we have difficulty comparing the veterans' health care system with the private sector, as you are really measuring apples and oranges and it's very difficult to weigh and measure what makes sense.

We think the veterans' health care delivery system is a cost-effective and efficient way. Acute care facilities, such as we're describing in these five facilities, are the areas where people go for acute needs. The outpatient clinics provide opportunity for ambulatory care service and in many instances help to diminish the need for inpatient service. What we are talking about here, in terms of fee basis, is in those areas where either the VA cannot provide the service, or in the areas that are so remote that it's difficult for the VA to provide, where they do provide for a fee-basis service. Florida ranks very high.

Unfortunately, that program can be abused. You can take a very senile senior citizen veteran who gets hooked up on a fee basis with a psychiatrist who sees him three times a week, and the person may sit and not say a word for an hour of therapy and the Federal Government might get charged for that particular care. But there is a large corps of people who do use fee basis who are provided quality care, and it has to be monitored and watched.

What we are looking for is innovative ideas, even beyond that fee basis or contract based care. I don't have any overall statistics for the VA. We can provide those and get those. I would be interested to hear from the Director of Bay Pines, who monitors it for the State, what his feelings would be.

Mr. MCELLIGOTT. Of course, there are two concerns with the fee program. The first is, of course, that eligibility for fee-basis care is restricted by law to limited categories of veterans. The other question is the one that the chairman speaks of, of monitoring the program when it is as widespread in a large State, such as it is here.

We do have physician-to-physician contact with the fee basis providers and physicians on our own staff, but that is not the same as being there and having face to face contact with the providers of the program.

The second part of your question, Mr. Chairman, I think had to do with the utilization of non-VA facilities, to provide services to veterans in the absence of VA facilities similar to the situation that was presented at the New Port Richey hearings.

My concern there is twofold. The first is if, in fact, the non-VA provider is a for-profit or investor-owned hospital, as is the case in the majority of many of the hospitals in this State, I do not feel that the Federal Government should be funding veterans' care with a built-in profit margin. Certainly the VA hospitals are not for profit; we certainly do not make a profit. I don't know that the taxpayers' money should be used to further enhance the profits of an investor-owned chain of hospitals.

My second concern I think would be whether or not the veteran would receive the quality of care to which he is entitled under the law, if, in fact, he were receiving it in a non-VA source. I think that is an open question.

Mr. EDGAR. I think that same fear occurred when we talked about the State-related homes many years ago, when we discovered, with some exceptions, that the State-Federal relationship has been on the whole pretty good. In fact, I think we upgraded many State homes that were pretty bad because of some Federal involvement.

There may be the possibility, as we dream of new and innovative ways to deal with this, of establishing a process for having outreach centers located near community facilities or in association with community facilities. It could be monitored.

I share your concern about the for-profit relationships of many of the hospitals, and I also would indicate that, through the procurement process, we would have to have competition. We couldn't have a sole-source procurement of that service. But it may serve the need of veterans who are in remote areas, where it would not be cost effective either to put a hospital or a full-service outreach clinic, similar to the many important full-service outreach clinics, but put a miniservice outreach clinic that could do initial intake, could service the pharmaceutical needs, could provide for some general services, and acute care services could be referred to other places. It's just an idea that we need to have some data on in terms of its approach.

Let me ask each of the other directors if they might comment on the original question about innovation and creativity.

Dr. WHITTINGTON. These are not all new, but I think they are all things we are looking at in Florida because of the pressure.

The hospital-based home-care program is one that fell in disrepute because of the fact that it was thought not to be cost effective. As time has gone on and the program has gotten a little bit older,

they find that it probably is cost effective. In this program a patient goes home and a team from a VA facility goes out once a week, once every 2 weeks, or once a month, just to check on the patient's health and probable health services in the patient's home. Participation in the program requires that the veteran have a wife, daughter, son, or someone else that is willing to provide the care. I think that is one program that can be expanded in Florida.

Two new programs, one at Tampa and one at Gainesville, was started during this last year. The day treatment centers are primarily directed to psychiatric patients. Those could be expanded. Many psychiatric patients with the support of coming in and spending the day don't have to be hospitalized. Certainly that's better for the patient, and I am sure it's cost effective.

The other side of the coin is the night hospital or the day hospital, where a more seriously ill psychiatric patient, who is in the process of being rehabilitated, may work during the day and come back to sleep at night.

We are looking at adult day care centers, and this is primarily with the older patient in mind, but it also would involve some of the severely disabled veterans, where they can live at home when they have an interested and concerned family, but everybody has to leave and there is nobody there during the day, if they could go someplace and be there, why they would have a better quality of life and it would be a lot more reasonable than putting him in an institution——

Mr. EDGAR. Let me interrupt you at that point.

Do you have such a thing in the State of Florida as community nursing services, where you have home health professionals who go around and provide individual services at the veterans' home?

Dr. WHITTINGTON. Yes. We have the Visiting Nurse Association and we do have contracts with them. We will make those services available if the patient is eligible for it.

Mr. EDGAR. Someone had suggested that we might try a model or a demonstration project in an area where you would try to provide a contract with a community nursing service to service the needs of certain veterans who could be serviced in their home with a twice-a-week or three-times-a-week visit by a community nurse associated with a "Meals on Wheels" program. That could alleviate the nursing home care and/or acute hospital care need for some veterans.

Dr. WHITTINGTON. We are doing that, but it's on an individual patient selection basis. It is not a formalized program for an area or something like that, and it could be looked at.

We are also looking at congregate living for the veteran who usually is up in years, who might be in one of our domiciliaries, but rather than building more domiciliaries, perhaps the Government could lease a facility with people to supervise these veterans. It would be the same type of patient as the Bay Pines domiciliary. We would identify the need for doubling the number of domiciliary beds by 1990.

We mentioned the mobile van.

Another area that the VA has been relatively slow getting into the field of ambulatory surgery. All of our hospitals use some of the minor surgical procedures on an outpatient basis, and that is

more reasonable than putting the patient in the hospital, doing a history and physical and keeping him in 3 to 10 days. That might be expanded. We have not gotten to the point where we are doing hernia repairs for some of the "minor" general-type operations.

The other areas, in patients with cancer that are receiving chemotherapy, probably the majority of that is done on an outpatient basis now. That, too, is a cost savings.

Mr. DOHERTY. I would agree with what Dr. Whittington and Mr. McElligott already stated. In addition, in Miami, to re-emphasize, I think there is a greater need for utilization of the fee-basis program. I think that additional resources have to be put into that program. I think it is extremely vital and one that is, in my opinion, very worthwhile.

In contacts with our local physicians, it would certainly indicate they are charging a minimal rate, that in my opinion the VA is getting some rather cheap medicine from our fee-basis physicians.

As Mr. McElligott just indicated, we should be raising the rate for these doctors. I am really surprised that some of them will see veterans for the moneys that we give them.

Also, we are working with some veterans organizations on the van possibility. We think this is a good one. As you know, Key West is 150 miles to the south of us and it makes it extremely difficult for our veterans to get to our clinics. So we are hoping that something will come of this real soon. We are also exploring a sharing agreement with the naval station at Key West to provide, if nothing else, ancillary services to our veterans in that area.

I am a firm believer in the outpatient clinic concept. I think it has demonstrated that we can obviate the need, and I hope the Veterans' Administration and our Congress will continue to go in this direction. I personally feel that the outpatient clinic sometimes provides a greater vehicle for care and treatment than the hospital.

Mr. EDGAR. Mr. Ruppen?

Mr. RUPPEN. Yes, sir. My fellow directors have pretty much covered the area, along with the information which is available through the planning board. I might say that Lake City is the smallest of the five, and we have quite a bit of real estate to cover, about 220 miles from the Atlantic Ocean, all the way over to the Chattahoochee. That, in itself, gives us some problems. We also have the 19 counties in Georgia.

We would like to do something for our inpatient group in order to eliminate those returning for readmission. However, that takes money and we don't start new programs unless we have the support and unless we can really carry them out.

I am glad to see that the van concept is being reinstituted. But there again, that will take some outpatient visits. We do a one-stop kind of treatment in our hospital, because of the distance our people have to come. They come from Thomasville, Ga. and areas such as that. We try to bring them in for a total examination and do an admission right there, rather than having them go back and forth to their homes, which some of these older gentlemen really cannot do. So we would like to improve on our inpatient clinics where we can. We do a lot of work with Gainesville, we do a lot of work with our other hospitals in the area, and we feel wherever our dollars would go, we will stay up with modern medicine. But I

feel our biggest problem right now is the inpatient to outpatient concept.

Mr. EDGAR. Dr. Riggin?

Dr. RIGGIN. Mr. Chairman, it has probably become apparent that I am the junior member of this panel. I am now also on the end of the line.

Dr. Whittington speaks for many of the ideas that have been generated by the hospitals, as chairman of the planning board. We all had members on that and are all working with a number of ideas that he has already alluded to.

I would also indicate that I think more should be done in the area of ambulatory care, I think both with the judicious placement of clinics, but also—and I hope this isn't begging the question—that with a modest expansion of some existing facilities, and additional resources that are provided for ambulatory care, that we could be seeing more patients.

I think that I detected in your original question what could be done in order to increase the number of nonservice connected patients. Again, with a modest increase in expansion of facilities, and then with greater support which would allow us to go further down into these levels of eligibility, which we are by law required to follow, we could provide more care. Our problem right now is not so much that of inpatient care. It is taking care of the outpatients.

I would like to refer to the fact that in addition to the hospital based home care programs—and we have one that has been operating for spinal cord injury for about 4 or 5 years, which I think has been quite successful—we have just been approved and funded for a medical hospital based home care program which will be instituted and which we hope also will prove to be instrumental in extending care without extending costs.

One other subject that was brought up earlier was that of the GRECC's. During the past fiscal year an offer for one GRECC for the southeastern region was made, and there have been 11 stations in competition for that. Three of the competitors are here in Florida—Gainesville, Miami, and us. Our proposal—and these are now still under consideration—was predicated upon attempting to extend care into the community, to develop a continuum of care, if you will, wherein no longer is it confined largely to in-hospital but using our own facilities and also linking up with community facilities that we would be able to develop continuing care especially for the geriatric patient. These are some of the things that we are considering.

Mr. HAMMERSCHMIDT. Does that include home care, Dr. Riggin?

Dr. RIGGIN. Yes, sir.

Mr. EDGAR. Let me lay out a challenge to all of you who are testifying at this point. We have listed out the statistics and the problems and the in-migration and the aging nature of the veteran population. On and about December, January, and February of next year we will be developing a report on our six visits. We will be coming up with legislative and regulatory change recommendations. We will be coming up with some of what we hope will be some innovative suggestions based on the testimony that you give.

I would ask that each of you go back and ask your staffs, your medical directors, your personnel within your hospital system and

outpatient clinic system, to think creatively and, some time between now and November, think about providing this subcommittee with a document—it doesn't have to be that long; it can be relatively brief—but the document would be your best shot at what you would like to see the veterans' health care system be 10 years from now, 20 years from now. What changes would you like to see us make, what demonstration projects do you think might be viable, what areas of research should we explore, what ways of providing better quality of care.

I share that challenge with you because I personally—and I am not speaking for the other members of my committee at this point—believe that if the veterans health care system does not stay on the cutting edge of health technology and provide quality health services into the future, that there will be threats, threats of the budget, threats of being swallowed up and gobbled up by other parts of the Federal Government, or simply a lack of priority at the Federal level.

And while I am not predicting that that's going to occur in the next year or two, I strongly believe that we must continue to pressure ourselves to be thoughtful and responsive to the changing health moods. The eighties and nineties are different than the seventies and the sixties and the fifties. The resources are different. The priorities are different. Numbers and demographics are different.

So the challenge I would lay out to you is to be a participant and to help this subcommittee shape that new direction with some thoughtful comments from your staff. We would appreciate any inputs that we could have in that area.

I also have a question which I would like to ask but, because of time, I am pressured not to ask—and this you can answer in a letter to our committee—and that simply is, what are the three things you are most proud of in your institutions, the things that you would like to show off to the world. If Harry Walters, the Veterans' Administrator, was visiting your hospital, what would you want to show him that you're most proud of.

Second, what are the three things that you are least proud of within your institution? What are the three needs that you have that you would like us to be aware of? What are the sore points or the open scars that you would like us to know about that are important in your long-term planning?

Finally, one question. Mr. Thompson, when I looked at this planned construction list for Florida—and I think you have done a good job of laying out your needs in this half-billion dollars—has consideration been made to try and consolidate nursing home unit construction rather than having a 120-bed unit built one time and another a couple of years later? Aren't there some efficiencies and savings if you can get into the pipeline let's say a 240-bed facility all being constructed at once? That's one question.

Second, if that is not possible, and you have to go on this shifting route, would it make any sense to put some of those nursing homes in different locations so that you might service the needs of veterans closer to their homes rather than double them up in one location or the other.

Mr. THOMPSON. I think I can answer the first part of the question. At one point in time we were of the opinion in the Veterans' Administration that the 120-bed nursing home was the most viable sizing to subscribe for. It has only been in recent years, with the advent of MEDIPP, that we have looked at the possibility of a single facility operating 240 beds, the concern being that they require substantial support services that are not necessarily available.

There also has been the problem of split funding, the budgetary restrictions that we have worked under in the past. Up until just the last 2 years, we had very substantial restrictions on the construction program. I would like to extend my appreciation to every member of the committee for the efforts that have been made in increasing the dollars that have been made available for construction, with nearly $1 billion this coming year. It is a three-fold improvement over just 2 years.

We are also looking at these new facilities as a potential, as the MEDIPP process develops, also having nursing home capability included in that construction, we may very well find that a 240-bed unit is an appropriate one-time inclusion in a project. But I cannot say definitely that those criteria have been developed at this point.

Mr. EDGAR. The reason I asked that question, we saw a nursing home, brand new, out in the Chicago area. It was at the Hines facility. I think it's awful, a brand new facility. Some architect got in and convinced the VA that they would like to build this facility, and they've got little triangular patios for the patients to go out and sit, a large area where they can go out and have a picnic. The triangles of the outside areas are larger than the therapy room, and they are filled with snow about 4 or 5 months during the year. There are little juts and jetties that were put into this facility so that the cost per bed is astronomical.

Now they have come back a few years later and said the facility is inadequate, we're going to put another facility on top of it, so you've got all these nursing home patients who are going to listen to the jackhammers come in and rip up the roof and put a second facility on top. I just have to think that the Central Office of the VA somehow goofed and that we should learn from our mistakes.

We have the Bay Pines facility. It's a brand new hospital. Let's congratulate that and let's learn from the mistakes of that construction and from the good points of that construction and not duplicate those mistakes someplace else. In the nursing home area we've got to get our costs down. There are some veterans facilities that are $90,000 a bed. The private sector is out there constructing similar facilities at about $30,000 a bed. I know there are special requirements that the Federal Government has, but we have got to clear to put those costs within reason. I say that as a fairly liberal Democrat, talking and sounding like a fairly conservative Republican. But I just think we have to do a better job of cost accounting in those facilities so that we don't make those mistakes.

Mr. THOMPSON. If I may comment, I would like to say that we share your concern and we are looking for opportunities. I think the Administrator, Mr. Walters, stated publicly recently that he would like to see us develop prototypes that could be transported to

several facilities instead of having an architectural design at each facility.

Second, as we did at Bay Pines, we built mirror image nursing homes which are very compatible. Innovation being planned, in the preliminary stages of planning at this time in this medical district, is to develop, either through our own construction or through a lease construction basis, nursing home facilities located in conjunction with our outpatient clinics as opposed to having to be located on the grounds of a hospital. This is a departure from any policy that we've had in the past, for the simple reason of the concerns for patient support. But this is something that we are looking at right now as an innovation.

Mr. EDGAR. I yield to my colleague for several brief questions.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

I want to ask three questions. I don't necessarily want you to respond now, in the interest of time, but if you would respond for the record on a hospital-by-hospital basis, Mr. Thompson, we would appreciate it, because I think the record wouldn't be complete without going into these subject matters. And they may have come up while I was out of the room. If they did, we'll forget it.

Question No. 1. Are your facilities completely adequate for the treatment of women veterans? Now, we know about Bay Pines; we've been there. But we would like to have it for the record.

Are you getting any complaints with respect to agent orange examinations not being complete or adequate? Are you completely current on this program?

Lastly, how is the vet center program working in Florida? Is your workload increasing, decreasing, or is it rather steady? I believe the regional director could respond to that question. You can respond later for the record.

Mr. THOMPSON. I would be happy to.

[Subsequently, the VA furnished the following information:]

In response to Mr. Hammerschmidt's three questions, the following information is provided:

(1) Except for psychiatric services at the VAMC Bay Pines, the remainder of the facilities in District 12 are completely adequate for the treatment of female veterans. The VAMC Bay Pines is correcting their lack of proper psychiatric facilities for female veterans with their ongoing major construction project, alterations to building 1 and 22 (last phase of replacement hospital project). Presently, the VAMC Lake City is the only medical center not providing inhouse gynecological services; Lake City transfers their female veterans to the VAMC Gainesville;

(2) The only complaints we have received with respect to Agent Orange examinations are regarding the waiting time for the scheduled exam and waiting on the results of necessary follow-up tests. These complaints have been minimal. We are current in providing examinations. As of an August 31, 1983 report Bay Pines has completed a total of 936 Agent Orange exams with 24 pending; Gainesville has completed 1098—11 pending; Lake City has completed 574—1 pending; Miami has completed 1101—63 pending; and Tampa has completed 986—28 pending. Pending means physicians are waiting on the final outcome of tests. None of the pending exams exceed 30 days;

(3) The six Vet Centers (Fort Lauderdale, Jacksonville, Miami, Orlando, St. Petersburg, and Tampa) in Florida have independently and collectively developed well-earned reputations in their respective communities for providing high calibre readjustment counseling services to an increasingly large number of Vietnam-Era Veterans and their families. Their services are well received and highly regarded by both the Vietnam-Era Veterans they serve and the community.

The Vet Centers have developed good working relationships and reciprocal referral networks with community agencies and service organizations, as well as key elements of local, state and federal governments. Progressively closer collaborative and

referral relationships are evident between Vet Centers and other components of the VA medical service delivery system to the betterment of veterans served.

The Florida Vet Centers continue to see large numbers of new veterans while maintaining ongoing counseling caseloads and support systems for those Veterans who have returned to productive functioning.

The following is a breakdown of the six Florida Vet Centers (with each grand-opening date listed) and their six-month averages of new veterans and veteran visits from the 1st ½ fiscal year 1982 through the 1st ½ fiscal year 1983 as compared to the Productivity/Utilization Standards for the Outreach Program.

	Standard	1st ½ fiscal year 1982	2d ½ fiscal year 1982	1st ½ fiscal year 1983
Miami, Mar. 1, 1980:				
New vets	(30)	22.6	24.0	28.0
Visits	(168)	223.5	177.3	211.5
St. Petersburg, Mar. 24, 1980:				
New vets	(30)	30.2	[1]16.3	30.5
Visits	(168)	254.2	166.7	204.7
Jacksonville, Mar. 31, 1980:				
New vets	(30)	63.3	65.3	63.9
Visits	(168)	301.0	274.6	255.0
Fort Lauderdale, May 14, 1980:				
New vets	(30)	31.5	35.7	38.0
Visits	(168)	205.2	197.7	218.0
Tampa, July 9, 1981:				
New vets	(30)	29.5	32.7	35.7
Visits	(168)	223.8	207.7	239.9
Orlando, Mar. 18, 1982:				
New vets	(30)	[2]26.6	35.3	47.9
Visits	(168)	95.5	194.8	242.0

[1] Figures for 2d ½ fiscal year 1982 for the St. Petersburg Vet Center are low because the then-team leader was also in the role of acting regional coordinator for the southeast region.

[2] The Orlando Vet Center had recently opened.

Note: 2d ½ fiscal year 1983 figures will not be completely available until the beginning of October. However, monthly figures for this period indicate that requests for services are increasing at each Vet Center.

Mr. EDGAR. Thank you.

Are there any final comments that you would like to share with us before we move to our next witness?

Mr. THOMPSON. Once again, we would just like to say we appreciate this opportunity.

Mr. EDGAR. Thank you very much.

Mr. HAMMERSCHMIDT. Thank you, gentlemen.

Mr. EDGAR. We would now like to deviate just slightly from our witness list and we will ask Dr. Silverblatt to come to the witness table. We thank him for his coming today and his participation. We also thank the person in the back who raised the objection that he was not at the table to answer questions. This will give us an opportunity to hear from him. Dr. Silverblatt, we are pleased that you're willing to jump in and give us some information and share it with us.

Would you just briefly describe for us your title and your operation?

STATEMENT OF CHARLES SILVERBLATT, M.D., DIRECTOR, VA OUTPATIENT CLINIC, ORLANDO, FLA.

Dr. SILVERBLATT. Yes, I am the clinic director of the Orlando Outpatient Clinic. We have been in operation since 1974. We were the second of the 35 satellite clinics now in existence, the first one being in Chattanooga. They preceded us by about 3 months.

We are also, I think, the busiest of the satellite clinics in Florida. Our present visit rate is about 68,000 visits a year. We are operating under an allocation of 70,000 visits.

I have to add that, although we are the busiest of the clinics, space-wise we are the smallest of the clinics in the State. This is one of these things, as Mr. Nelson mentioned earlier. It was through his efforts that we did get a 14,000-square-foot expansion 3 years ago. This certainly did help us. But up to that time we were operating with only 18,000 square feet.

To answer questions relative to the number of service-connected veterans, for the past 2 years our service-connected ratio has been 88 percent of our total visits. If we include what we call the nondiscretionary patients, that is, the Public Law 91-500 AA's, the POW's, et cetera, then that figure becomes 95 percent. So at the present time we are really seeing only 5 percent of veterans who otherwise would be eligible under the ambulatory care law.

We do see all veterans and evaluate them for hospitalization. However, with our present space, our present staff, and our present budget, there is no way that we can take care of all the NSC patients in our seven-county area.

Mr. EDGAR. What kind of budget would you need to take care of at least 50 percent of those veterans?

Dr. SILVERBLATT. This question was asked of me, I guess, 3 or 4 years ago when Senator Stone held a hearing here. I have forgotten what I answered him. But I think if we were seeing nonservice-connected patients at a rate that is normally seen throughout the rest of the country—that is, about 30 percent—I would have to say that we would have to have at least a 30-percent increase in our budget.

But it is not just dollars. You have to have staff and space. We cannot possibly see another 20,000 or 30,000 visits a year, which we could easily see in our seven-county area. I don't think there is any question but what we could generate 100,000 visits in this seven-county area.

We are the only primary care facility available to 220,000 veterans living in this seven-county area. Now, it is true that they could go to Gainesville, which is roughly 120 miles from Orlando, or they could go to Tampa, which is 80 miles from Orlando, but is considerably further from other parts of our seven-county area. But this is hard to do, especially if you're acutely ill. So these veterans come to see us. We would like to be able to take care of them, but we just can't do it with our existing space and staff.

Mr. HAMMERSCHMIDT. Dr. Silverblatt, you see them all on a first-time admission?

Dr. SILVERBLATT. Yes, sir, all patients who enter our clinic are evaluated as to their immediate need.

Mr. HAMMERSCHMIDT. So you would have a record, I suppose, of non-service-connected veterans that were turned away because of lack of——

Dr. SILVERBLATT. I would have to tell you that we do not have such a record. We could dig it out for you, at least for the past fiscal year, but as Mr. Thompson indicated, the VA just doesn't keep figures like this.

Mr. HAMMERSCHMIDT. Let me ask, what happens to those non-service-connected veterans? Do you have a social service——

Dr. SILVERBLATT. Yes, sir, we have a fairly adequate social service. Unfortunately, in our seven-county area, there are really no other places for these people to go. The majority of them are borderline economic problems. The county of Orange maintains a health clinic, but you have to be almost a pauper to be eligible. I think their income limitation is $500. So if a person is drawing social security, he is probably not eligible.

I don't know what they have in Brevard or the rest of our counties. I don't think they have any significant free clinics, if I could use that archaic term. So we don't have anywhere for these people to turn to.

Mr. EDGAR. You don't have a State income tax, do you?

Dr. SILVERBLATT. No, sir—fortunately.

Mr. EDGAR. Your State doesn't provide, then, the kind of services that Pennsylvania or New York or Michigan may provide in terms of medical care for indigent person who are, let's say, nonveterans?

Dr. SILVERBLATT. That's right. My past experience in medicine has been essentially in the Midsouth, in the Memphis and Little Rock area, and both of those cities, for example, have university hospitals that provide enormous amounts of medical care. We just don't have it here in this seven-county area.

Mr. EDGAR. Do you have additional questions?

I yield to Bill Nelson.

Mr. NELSON. Thank you, Mr. Chairman, for yielding.

Doctor, would you share with the committee something of the overload that occurs at your facility during the winter, when we have a great number of our brothers and sisters from the more from the more colder climes coming to enjoy the benefits of Florida and its climate.

Dr. SILVERBLATT. Of course, there is always the crowd. I mean, 300 visits a day in a clinic our size is a heavy day. Sixty to seventy walk-ins, when we have a triage consisting of a physician assistant and one physician, it's kind of hard to cover it. Somehow we manage to do it.

But the big problem with the tourist trade is that these patients have been used to getting dental care and eyeglasses and other accessories in our more northern facilities, and we just can't give it to them. I don't know how they get dental care in the more northerly VA facilities, but we can't give dental care to anybody except someone who is clearly adjunct or clearly entitled to dental care. This constitutes our single biggest problem.

Mr. NELSON. Four years ago, when we had then Administrator Max Cleland here, he said, as he was touring with you and me in the facility, that it was one of the more overcrowded facilities that he had seen in the country.

Dr. SILVERBLATT. I thought he said the most. [Laughter.]

Mr. NELSON. I think he did, as a matter of fact.

Mr. EDGAR. Let the record show he said "the most."

Mr. NELSON. He commented to me later that day, after the tour, that we would finish this expansion and we would still be overloaded.

Dr. SILVERBLATT. Right.

Mr. NELSON. Can you share with us your observations of how we were overloaded before you had expansion and compare that to the overloading now that you have had a completed expansion?

Dr. SILVERBLATT. Well, at the time we were operating, as I said earlier, with 18,000 square feet, and we were seeing 50,000 visits. An effort had been underway for some time, as you know, to get an expansion of the clinic at that time, but when Mr. Cleland wheeled into the clinic, he looked around the lobby and he said, "Where's your telephone?" I said, "What do you mean?" He said, "I want to make a call to my office in Washington." I wheeled him back behind the reception desk and he called the gentleman in Washington who was in charge of construction and told him he wanted this clinic expanded in Orlando. Within 3 weeks they were putting up boards and nailing nails. We had no privacy, no patient privacy whatsoever. Everything was crammed in. But we did it.

Now, I'm proud of what we did because I think we set a pace in this country as far as the VA—and let me state this point, that I have 27 years in the VA and I am a strong believer that the VA provides the finest medical care available anywhere. I don't care how many criticizers or detractors we have, our service is good. It is on a par with anywhere.

But when you have to operate under such cramped conditions, and when you have to see people who need care turned away, it is very hard on morale. It is hard on physicians' morale and other employees, also.

I don't know whether it was last year or early this year, that Senator Chiles introduced a bill, or he proposed to introduce a bill, that would indicate there would be annually an inventory of veterans in this country and a redistribution of funds accordingly. I don't know whatever happened to that bill, but as I read it, it sounded like it was just aimed at us. We need help in the central Florida area, and whether we have a hospital or not, there is a tremendous need now, as someone earlier said, for improvement in our service to the veternas who are technically eligible under the law.

Mr. NELSON. Mr. Chairman, may I ask of you, or perhaps of Mr. Thompson, if he is still here, has there ever been any experimentation with a mobile outpatient unit in the Nation?

Mr. EDGAR. Yes, we discussed that while you had stepped out. There are mobile units and there are some experiments even here in Florida being thought about to provide for some mobile units. They work in some instances and have some liabilities in some instances in terms of the amount of service they can provide and the ability to advertise their location. But they are a helpful resource and a number of the hospital directors indicated that they are looking at that option for those facilities.

Dr. SILVERBLATT. If I might add, there is one thing that seems very attractive to me, and it particularly would be good for us between, say, Daytona or Volusia and Brevard—that is this experiment that is going on in San Francisco with the VA. They have identified a corps of private physicians who have been willing to undertake the day-to-day care of veteran patients. They make regular reports to the chief of ambulatory care at the San Francisco VA and they take payment that is considerably less than what they

would normally charge in private situations. It is my understanding that this is working out quite well.

By the way, we proposed last year to set up such a van proposition. We even talked with the Patrick Air Force Base people about using their space over there on our treks to Cocoa and south. But money is the issue and it just isn't available.

Mr. EDGAR. We saw some limousines down in Palm Beach. You might ask some of the owners of those limousines to buy you a van—at least in the short term. [Laughter.]

Dr. SILVERBLATT. That's another factor that hasn't been mentioned much here, that transportation—you people from the bigger cities up north and what not, you're used to good transportation, rapid transit, and so on. There isn't any in central Florida.

Mr. EDGAR. Except for Disney Productions.

Dr. SILVERBLATT. Well, yeah.

Mr. EDGAR. I think the point is well taken, in terms of transportation needs, particularly with the emerging population. As I indicated earlier, John Paul and I serve on the Surface Transportation Committee and we spend a lot of time looking at public transit needs and trying to provide some additional help. But it is very difficult, particularly for the aging veteran population, to go long distances.

Dr. SILVERBLATT. If I might leave you with one thought—I guess I could be criticized for even raising the issue—but we can't forget that with all the world problems that are going on now, we can't assume that by the year 2000 there is going to be a decrease in veterans. We don't know when there's going to be an international conflict, a world conflict, of some kind. I happen to have been one of the 5,000 who were on active duty in 1946 when the Veterans' Administration was in a horrible situation with returning veterans. They just didn't have any doctors.

So the Department of the Army and the Navy loaned them 5,000 doctors for 2 years. I don't think we ought to wait for something like that to happen the next time.

Mr. EDGAR. Thank you.

We have one additional question from Bill McCollum.

Mr. MCCOLLUM. Dr. Silverblatt, I am really happy that I got to inherit from Bill Nelson the physical facility of this clinic, and because of that you and I had a nice long conversation and a tour a few weeks ago and talked about the long-term problems of the clinic, not related directly to hospitals or other care facilities.

You made a good point to Bill Nelson a minute ago in response to his question about the expansion of this and so forth. But as I recall, you and I talked about the problems that would occur after this next expansion with the actual physical site location and the ability to expand further there. The next stage, which you and I both think isn't that far away, we're going to have to consider even another site location for an outpatient clinic, aren't we?

Dr. SILVERBLATT. I think so. There is a clear-cut limitation of space. The maximum amount of space that we could add right now is 15,000 square feet. That's it.

Mr. MCCOLLUM. Thank you very much.

Mr. EDGAR. I just hope the two "Bills" don't get into a contest as to where that location site should be.

OK. Thank you, Dr. Silverblatt. We appreciate it.

Mr. EDGAR. I want now for the veterans' organizations to come as a panel to the table. Mr. Harry McDowell, Mr. Tracy Taylor, Mr. Charles McLeod, Mr. Kenneth Doncaster, and Mr. Daniel Cloutier. I would ask that you all come to the table at this point.

Before you begin, I would like to compliment Kenneth Doncaster. Ken, I want to thank you for your diligence. Ken was with us the other day over at the hearing that we held in Mike Bilirakis' district and brought us some of the press clippings from that particular event. We appreciate your clipping service for the subcommittee.

I would like to first hear from Mr. Harry McDowell, commander, Department of Florida, the American Legion. Mr. McDowell, we really appreciate your patience in listening to the other witnesses. But I think it was probably helpful for you to hear the extent of health care services, needs and problems that we face, and I appreciate your willingness to sit through that. We look forward to hearing your statement.

Because of the pressure of time, I really would hope that all of you would summarize your statements, where possible. The full text of your statement will be made a part of the record; that is, every word that is printed will be part of the official testimony, and you will receive a copy of that and your extemporaneous comments will also be part of that official record. So if you could summarize for us and be as brief as possible, and try not to repeat some of the comments that we made earlier, we would appreciate that very much.

Mr. McDowell.

STATEMENTS OF HARRY F. McDOWELL, STATE COMMANDER, FLORIDA AMERICAN LEGION, ACCOMPANIED BY TRACY TAYLOR, CHAIRMAN, DEPARTMENT OF FLORIDA, VETERANS' AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; CHARLES M. McLEOD, LEGISLATIVE COMMITTEE MEMBER, DISABLED AMERICAN VETERANS, DEPARTMENT OF FLORDIA; KENNETH E. DONCASTER, LEGISLATIVE CHAIRMAN, DEPARTMENT OF FLORIDA, VETERANS OF FOREIGN WARS; AND DANIEL J. CLOUTIER, SR., NATIONAL SERVICE OFFICER, AMVETS

Mr. McDOWELL. Mr. Chairman, gentlemen of the committee, first I should probably introduce my friend with me, Mr. Tracy Taylor, to my right. He is the chairman of the Department of Florida, Veterans' Affairs and Rehabilitation Commission within the American Legion itself. He really is the expertise individual of the American Legion within the State. I think they allow me to make the presentations just to coddle me a little bit. I really believe that's about what it boils down to.

Gentlemen, we of the American Legion, the State's largest veterans organization, welcome the opportunity to present to you the areas of our concern dealing with the health care and delivery of health care services to the State of Florida.

We are particularly pleased that members of the committee who do not reside in the Sun Belt have taken time to come to the Sun-

shine State to learn, firsthand, the severity of the problems facing the veterans of this State.

As has probably been stated before, the most obvious of these problems is the tremendous influx of veterans that come to the State of Florida on a seasonal basis, as well as those who are continually moving to the Sunshine State on a permanent basis.

The estimates you have heard, of 3,000 to 5,000 moving in, that is a Veterans' Administration figure. It is my understanding that this is the number of Veterans' Administration files that are transferred on a monthly basis. This does not account for those veterans who do not have current active files with the Veterans' Administration. Therefore, the number of veterans, as we have stated before, and as Mr. McCollum seemed to be aware of, and their families moving into this State are considerably greater than the estimates that we are hearing.

For those of us who reside here, it creates a monumental problem. The Federal bureaucracy and reaction time of the Government to these types of shifts of population are gaged in years, and the reaction time of Federal agencies for these types of adjustments takes so long that in-depth preplanning is necessary to meet current and projected needs.

As we all know, through the aging process more medical care is needed. The World War II veteran is now faced with this increased medical attention. We need those services that the VA furnishes.

We would like to address the current status of the outpatient clinics, as they currently exist here in the State of Florida. We are fortunate that the five outpatient clinics that are currently operational are manned by individuals that are dedicated to their service. Were it not for them, we in the State of Florida would be surely short-changed.

I base these remarks on the fact that three of the five clinics in the State of Florida have already exceeded their budgeted capacity for veterans visits in July, only the 10th month of the fiscal year. As an example, on a projected basis, the Riviera Beach facility is budgeted for 46,000 veteran clinic visits, and, in fact, the current projections are that the clinic will have in excess of 55,600 veterans visits this fiscal year.

The same applies, without going into the details, of the Oakland Park facility, and the Fort Myers Clinic, which is closer to my home, down at Lehigh Acres.

The two remaining clinics that are not projected to exceed their budgeted visit capacity are going to be upward of 95 percent of the budgeted projection. This leaves absolutely no latitude for future growth. It is imperative that adequate budget increases be allowed for these facilities and that they be immediately planned for. We would encourage that more outpatient clinics be established within the State of Florida to meet the ever-increasing needs of our veterans.

With the outpatient clinics being one of the primary entry levels for existing medical centers, the outpatient clinics have referred almost 3,000 veterans for care that the outpatient clinic cannot provide. It is our opinion that this is also an indicator of the need for more and larger outpatient facilities as well as more hospitals.

As an organization, we do not feel that it is our purpose here to cite problems of individual veterans, or with any particular outpatient clinic in the delivery of that service.

As an overall function of the agency, we feel that the outpatient clinics and medical centers are doing a tremendous job in the delivery of service to the veterans of this State. We in the veterans' community feel that we have an outstanding rapport with the Veterans' Administration personnel.

We would also bring to this committee's attention that Medical District 12, which comprises a portion of Georgia and the majority of the State of Florida, currently has the highest percentage of nondiscretionary visits of any of the medical districts. The 12th Medical District is currently running at a 73 percent nondiscretionary visit basis, compared to 55 percent nondiscretionary visits of the overall Veterans' Administration total. I think that figure was pretty close to 75, as one of the Directors mentioned a few moments ago.

The Florida American Legion has been instrumental in observing and participating in the 30-year study of the needs of veterans. We would like to commend Mr. Malcolm Randall for the interaction this organization has had in the planning process through the MEDIPP. We feel that the 30-year study as an overall document is a realistic plan for the future needs of the veterans of the State of Florida.

The medical district plan currently projects the need for 726 additional hospital beds in Medical District 12 by 1990. This is an immediate situation that must be dealt with right now.

We go into the populations of beds. I think you're all aware of it and I won't go through that particular paragraph, the 1.5 beds per 1,000 compared to the national average of 3 beds per 1,000.

One concept that has been proposed as an alternative to expansion of bed facilities for domiciliary care we feel would be a wise and good usage of Federal dollars to investigate and expand the concept of the adult day care center.

Many veterans that will need domiciliary care in the future will fit into a category that would be conducive to an environment of a day care center where they would have supervision during the day and be able to return home to be with their family members during the time that the members of their family would also be there. This concept is bound to be a maximum usage of the dollar for those that are involved within the program.

The American Legion has gone on record as endorsing this as a most realistic and workable proposal. We also feel that the concept of hospital-based home care programs is an idea use and format for necessary care for these veterans in need.

We would encourage this committee to seek out this type of alternative care for veterans, particularly here in the Sun Belt area.

We would like to conclude this presentation with a statement regarding our future needs in the area of new medical facilities. Obviously the need is great and will become greater in the future. A new medical center in south Florida is needed and is in the planning stages.

Central Florida is also under consideration, and I assure you the American Legion will actively participate in supporting this facili-

ty. We would hope that these facilities will be placed in locations that are most beneficial to the demographics of the veteran population.

It will take a united effort on the part of the veterans organizations and the congressional delegation to insure the veterans of Florida are served properly.

We again want to sincerely thank the Members of Congress for taking this time to come to Florida to listen to our positions in this matter. We are especially proud and wanted to tell you so of Congressman Dan Mica, who is a member of this committee. He has done a tremendous job on behalf of the veterans.

We also wish to recognize and commend an individual who, although he is a freshman Congressman, has immediately gone to work on behalf of the veterans of the State of Florida. I might add that this gentleman has been a commander of a Legion post twice here in the Department of Florida just within the past several years. We sincerely appreciate everything that Mike Bilirakis is doing on behalf of the veterans affairs. His seeking out an appointment to this committee is certainly an indication of his dedication to the veterans of the State of Florida.

Gentlemen, again I wish to thank you for visiting the Sunshine State. My friend and I, between us, will be happy to answer any questions that you may have regarding the items we have testified to and heard here today.

Mr. Chairman, let me state that I am a past resident of Johnstown, Pa., and I have a mother and some of my family are still there. But I still cannot say that I am sorry for ever having moved to the State of Florida. I love it.

[The statement of Harry F. McDowell appears at p. 101.]

Mr. EDGAR. Everybody I have met in the State of Florida has come from some place else. But it's nice to know that a former Pennsylvanian has assumed the responsibility that you have, and we appreciate your statement.

Before we move to questions, I would like to allow the others on the panel to make a word or two and share their comments.

I would underscore the statement you made about Dan Mica and Mike Bilirakis. As we said earlier, this is the most nonpartisan committee that I have ever served on in Congress. It has a reputation of being a committee that cuts across both party lines and ideological lines—conservatives, moderates, liberals, Democrats, and Republicans. Both Dan and Mike have distinguished themselves, Dan for a little longer time. But Mike has come in with both feet.

I might indicate to you that Mike Bilirakis has, in fact, gone with us on several of our field visits to other parts of the country, and he is very eager, as are other members of our subcommittee, in learning as much as he can about veterans' needs throughout the country and not just in a parochial way for his particular area. It was because of their leadership that we have spent as much time as we have spent in Florida.

I might say on a personal note that of the six hearings we have had across the country, or that we're planning to have, Florida gets the most days. In Boston we were in for 1½ days, and 2 days is usually our maximum. We have stretched our visit here in Florida

over a longer period of time. Some people have reminded us that we are not junketing, because if we were junketing, we would have come in December, January, or February. I think we made a big mistake coming at this time, but it shows some of our interest and diligence.

Let me ask Tracy Taylor and the others to give their statements. Again, I must ask that you be brief.

Mr. TAYLOR. I am only supporting the commander on the extemporaneous side, Mr. Chairman. Thank you very much.

Mr. EDGAR. OK.

Charles McLeod, do you have any additional comments you would like to underscore or questions that we asked earlier that you would like to answer?

STATEMENT OF CHARLES M. McLEOD

Mr. MCLEOD. Yes, Mr. Chairman. Just a couple of comments. My prepared remarks have been provided to you and the members of your subcommittee, so I won't go into those.

During the hearing and testimony I was referring back to a copy of the hearings conducted by this subcommittee in June of last year. I think really the speakers that came forward today have given you the same basic information that was given 1 year ago. It is that Florida has serious problems in meeting the commitment to service the veterans that are living here now and the ones that we project will be moving to this area in the foreseeable future.

Mr. Chairman, there is a couple of things that I see as a means to enable the Veterans' Administration to better meet the needs of these people, and you, yourself, hit on a couple of those earlier in your comments, that we have to look at this from a new standpoint. The old system of building a hospital takes time. We don't have the time here in Florida, as Mr. McCollum indicated earlier. The veterans here in Florida need help now, not 5 years or 10 years down the road, but now.

The establishment of a State veterans' home, the committee testified earlier this morning that Florida's application is pending, that it will be approximately 1986 before the money comes through. Yet, with the aid of this committee, is it possible that that funding could come through quite a bit earlier, creating a product and filling a need for veterans in this particular area?

Another problem that has become very apparent to us is that we have a number of VA hospitals that are doing an extremely adequate job in meeting the inpatient needs of our veteran population. As was indicated by most of the speakers from the Veterans' Administration, our problem lies in outpatient treatment, specifically the nondiscretionary type of person, the discretionary care end of it. Adequate funding, the possibility of looking into additional hours of operation of outpatient clinics, getting away from the typical 9-to-5 scheduling routine, the possibility of adding an additional shift for special examinations to be conducted after the working veteran is off work. Instead of now, if the veteran has an examination, if he is lucky enough to be working in this day and time, he is required to take time off from work. He is required to report in at 8 or 9 o'clock in the morning; it may be the next afternoon before

he returns back to his home again. Yet, with proper scheduling and additional staffing in these positions, it is possible this man may be able to come in at 8:30 or 9 o'clock at night, complete an examination and go home.

Mr. Chairman, I totally agree with your earlier comments, that we need new ways and we need innovative ways to meet the needs of the veterans here in Florida. That's all I have to say. Thank you.

[The statement of Charles McLeod appears at p. 109.]

Mr. EDGAR. Ken?

STATEMENT OF KENNETH E. DONCASTER

Mr. DONCASTER. Mr. Chairman, I have shortened my speech up somewhat. I am pleased and honored to represent the Veterans of Foreign Wars, Department of Florida, as we once again consider the health care needs of Florida's veterans.

I have studied in detail the 30-year study and the subsequent one on siting. We consider these reports to be a giant step in the right direction. But as to new VA hospitals, VFW's main concern has to be the rate of implementation. The VFW feels that solutions to the medical problems of Florida's veterans have been long overdue. We feel that authorization and construction of new facilities should be on a crash or emergency basis, short-circuiting the normal bureaucratic procedures wherever possible. We fear that unless this is done, we will find the new facilities already inadequate to the need as soon as the doors are opened several years from now.

To establish the point, let me tell you that the first time I testified before a congressional body was in 1949, when I appeared before the Veterans' Affairs Subcommittee of the U.S. Senate Labor and Public Welfare Committee chaired by a young Florida Senator named Claude Pepper. I am glad to hear he is still having birthdays. He has been a good friend and give him my best regards. Our objective then was a new VA hospital in Gainesville, Fla. Eighteen years later, VAH Gainesville opened its doors. What I am saying, gentlemen, is this time around, let's don't take so damned long.

As to the outpatient clinics, the VFW says put them where the veterans are, pure and simple. I think the same should go for the hospital program as well.

One other major point that I do want to make really follows upon Tom Doherty's comments concerning the fee-basis outpatient program. I think this has been thoroughly underestimated and underused, and I have suggested in my written report to you that your committee conduct a thorough analysis and study of exactly what has happened there, what are the attitudes of the doctors in the private sector who are not participating, why are they not participating, are they not being paid on time, are the fees too low—what is the problem? If we can get all of the doctors that are members of the AMA to participate in this fee-basis program, we can get treatment for the veterans. I think if we ultimately get to the root of that problem, you will virtually eliminate the need for so many more outpatient clinics.

Thank you very much, sir.

[The statement of Kenneth Doncaster appears at p. 113.]

Mr. EDGAR. Thank you.

Not only is Claude Pepper still having birthdays, but he is still coming up with new legislative ideas. It is tough for some of us to keep up with him. So I appreciate that comment.

Dan, do you have anything you would like to add?

STATEMENT OF DANIEL J. CLOUTIER, SR.

Mr. CLOUTIER. No, Mr. Chairman. Rather than reiterating what has already been said, I would like to move to have my testimony be accepted as part of the record.

Mr. EDGAR. Without objection, all the testimony will be made a part of the record. We appreciate your abbreviating that.

[The statement of Daniel Cloutier appears at p. 117.]

Mr. EDGAR. Let me just take a moment to compliment all of you on your statements. I particularly appreciated the comments about the adult day care center program. I think that is an innovative idea whose time has come. I also appreciated your comment about looking at some flexible hours of using existing facilities. We have got to do that in a number of areas, including our education facilities, that often get closed off for periods of time that could, in fact, be utilized in education. In the health care area I think we can do a better job of expanding the service with new personnel refreshed, taking that time. That may be an option in some instances for us to expand the services of clinics that are, as Dr. Silverblatt indicated, in extremely cramped space. We have to look at that option.

I laid out a challenge to the hospital directors, and I brought along a challenge for the veterans' organizations as well—actually, two challenges. One challenge is in terms of your national organizations. There is a real tension that is beginning to brew. Ken mentioned the fee basis program and contracting care. We, as legislators, are bombarded by Federal employees and others in a variety of areas who tell us don't support contracting out under any circumstances because it means jobs for us, particularly as it relates to the military, but they get suspicious every time we talk about contracting out of facilities.

We also hear from your national organizations every year when they come to Washington. There's a paragraph in there, a national statement that's verbatim, year after year, and that is that we should not let the veterans' health care system get swallowed up by Health and Human Services or the former HEW. Every time one of us comes up with what we think is an innovative idea, similar to the idea that Mike Bilirakis is pursuing in his area of locating an outpatient clinic in and near a community hospital and sharing resources, sharing services, we're told:

> Wait a minute, you have got to be cautious on that because we don't want the mainstreaming of veterans' health care system into the services of the private sector because that will just nudge people into thinking that there is no unique role for the Veterans' Administration's health care system.

So there is this tension.

I think the challenge is for all of you to work with your national organizations and help them to set up some priority studies and research as to how to reallocate resources, what the national resources are in the veterans' system, and help them to understand

that when some of us come up with innovative suggestions—some of which you have suggested—that we are not attempting to dilute the veterans' health care system but, in fact, we're trying to keep the existing system working as well as expand that system to service the needs of veterans. They have been very good at servicing veterans' needs over the many generations.

But when they hear of some of our ideas suggesting a slight change in direction for the VA, they get very nervous until they see the fine print. It would be helpful if you could work with them.

The second challenge is to come back to us with additional ideas on creative approaches, because I think within the veterans' organizations you have physicians, you have nurses, you have technical people who service these hospitals, both in the private sector and in the Veterans' Administration. I think that a lot of good ideas are out there.

We mentioned earlier John Naisbitt's book on Megatrends. He reminds us over and over again that trends are from the bottom up, not from the top down. One of the reasons we have come out to the field is to hear what is happening at the local level. You have great needs here and you're setting some trends. You are under a great deal of pressure because of the in-migration of population. I think your veterans' organizations can help us and help other areas in the country, because you are not the only growing areas. There are some areas that are growing, and you can also——

Mr. DONCASTER. Where? [Laughter.]

Mr. EDGAR. Well, Texas, California, Oklahoma, Louisiana, there are a few other growing areas, mostly in the South and West, but areas of growth.

I did not mention this for the record, but every 10 years, as a result of redistricting, we redraw the boundary lines of the 18 States of the Northeast-Midwest region of the country. We lost 17 Congressman. Four new Congressmen were selected in Florida, and the rest of the 17 were scattered around the South and West. That indicates in just a 10-year period, if each of those Congressmen represented 500,000 people, 17 times 500,000 people moved out of the Northeast and Midwest and moved someplace else in just that 10-year period.

I am as concerned about the rehabilitation and reconstruction commitment to the older communities that are losing the population as I am to the areas of in-migration, but you can tell that the shift has taken place, a catastrophic shift. Very few people in 1968 or 1969 would have predicted the extent of that shift, and what I hear from the testimony today is that you want us to have at least foresight to know that the shift is continuing and it looks like it's going to continue through the year 2000.

I yield to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Gentlemen, I want to thank all of you for being patient and taking the anchorman position in these hearings. We have one other group to listen to after you, one other panel. But you literally are an anchor to our legislative efforts.

Because as you know, as you meet in your posts and your departments, you come up with your consensus, and then you take your resolutions to your State conventions, and then you bring them on to the national conventions, and you finally sort them out and

bring them to us in the form of a national commander's statement. I have never seen a lack of willingness or initiative from any of your service organizations to express your views to us.

I think maybe the chairman's challenges today might be a catalyst to new thinking. Indeed, in your statements here today you have brought us new thoughts. We are very appreciative of that.

I know you hear this all the time, but we couldn't get along without your national legislative representatives and the way they serve us there in Washington, whether it's the Legion or the VFW, the DAV, AMVETS, PVA, POW's, all of them make a great and valid input to us. We are most appreciative.

I won't take any more time because we do have this other panel behind you. But thank you so much.

Mr. EDGAR. Are there any other questions from my colleagues? Thank you very much for your testimony.

Mr. EDGAR. Our final panel involves Mr. Connie Lukas, president of the central Florida chapter, Paralyzed Veterans of America, Mr. Sam Moody, member of the American Ex-Prisoners of War, and Maj. Gen. John Moench, U.S. Air Force, (Ret.) We welcome all of you to the witness table. We appreciate your patience. It has been a long afternoon. I hope you have profited from the statements of others.

The full text of your statement will be made a part of the record, word for word. We ask that you highlight those issues which were not focused on in detail. We will start with Connie Lukas.

STATEMENTS OF CONNIE LUKAS, PRESIDENT, CENTRAL FLORIDA CHAPTER, PARALYZED VETERANS OF AMERICA, INC.; SAM MOODY, ON BEHALF OF THE AMERICAN EX-PRISONERS OF WAR; AND MAJ. GEN. JOHN MOENCH, U.S. AIR FORCE (RET.)

Mr. LUKAS. Mr. Chairman and committee members, thanks for coming to Florida. I don't have a prepared statement. I would just like to make some comments.

I would like to compliment Dr. Silverblatt and the entire staff at the Orlando VA clinic for the fine work and the fine care that they do provide, knowing their budgetary restraints and their amount of patients that they see every year. I would also like to compliment Mr. Silver and Dr. George, who run the spinal cord unit over at the Tampa VA Hospital.

What I think we would like to see happen, knowing that there is some expansion going to be happening, some new buildings, is the expansion of the spinal cord injury unit, which I understand is on the books. I would like to see that happen a little more quickly, if it is at all possible. I think they currently have 42 beds and it is not at all adequate for the amount of spinal cord injured veterans that we currently have.

We would like to also mention Mr. McCollum's statement, that in Florida the need is now. The veterans are here, they are coming here. I believe the VA budgetary dollars should follow the veteran. If they're here, the dollars should follow.

Mr. EDGAR. Thank you very much for your statement.

How many members do you have in your paralyzed veterans organization?

Mr. LUKAS. In our local chapter we currently have about 120. We estimate that that's probably less than half of the catastrophically disabled veterans in Central Florida.

Mr. EDGAR. What kinds of uniquely home needs do those particular veterans have that may not be being provided at this point?

Mr. LUKAS. Well, most of the problems medically that paralyzed veterans are faced with are usually of a long-term nature, such as decubitus ulcers, renal problems. Home care could be provided by nurses that come to the home, perhaps, looking for alternatives to hospitalization, which lacks the bed space. Hospitalization is not available oftentimes.

Oftentimes spinal cord injury people are either put on a waiting list or put on another medical ward that is really not adequate to properly care for spinal cord injured veterans.

Mr. EDGAR. I would hope that you would accept the challenges that we have laid out to the other groups, and particularly be thoughtful about innovative ways that we could respond to paralyzed veterans. Your national association has been very helpful to us. We have tried to work with them. We, as a committee, have had the privilege of visiting the Chicago area spinal cord injury center and looking at some of the technical details of how to provide quality care for spinal cord injury. We wanted especially to hear from you as a representative of that organization because we think the veterans' health care system is unique in many areas, but particularly in providing specialized services to the victims of spinal cord injuries.

Mr. LUKAS. I would just like to add one thing. I would like to see, if at all possible, some of our non-service-connected veterans being able to receive some of the same kind of quality care that we receive.

Mr. EDGAR. Thank you. Your statement is well taken.

Do any of my colleagues have any questions of this witness?

Mr. HAMMERSCHMIDT. No. But I, too, want to thank you very much and thank you for your patience in waiting to testify. We very much appreciate it.

Mr. LUKAS. It has been a pleasure.

Mr. EDGAR. Next is Mr. Sam Moody, who is a member of the Ex-Prisoners of War. Mr. Moody, I might add for the record that in our previous hearings in one location we were trying to consolidate our witness list and we failed to invite the Ex-Prisoners of War. We heard about it——

Mr. MOODY. I heard about it, too.

Mr. EDGAR. We made sure that we didn't make that mistake here. Again, we apologize for the lateness of the hour.

STATEMENT OF SAM MOODY

Mr. MOODY. I am also the past national commander, Mr. Chairman, of the American Defenders of Bataan and Corregidor.

At 1:30 this afternoon there was about 60 of these red hats to show support to this committee that the POW's do appreciate everything you're doing. We are most grateful, sincerely, for the passage of Public Law 97-37. The prisoners of war have been the most misunderstood veteran for many, many years, and now with the

passage of Public Law 97-37, Florida has become the leader in health care for the prisoners of war. We have over 4,000 in the State of Florida at the present time.

Now, with the new system of giving the prisoners of war the physical exam, then the hearing on whether or not he's eligible for compensation and this type of thing, it has been a godsend to all the prisoners and they are very grateful to the House Veterans' Affairs Committee and Chairman "Sonny" Montgomery for all of those efforts on behalf of us.

I am going to make this very short because I want to turn it over to General Moench. But I do want to say this, that above all else, we are most grateful to Dr. Silverblatt and his entire staff down at the Orlando VA clinic. They have taken care of over 68,000 veterans as of September 1. With a workload like this, Dr. Silverblatt is actually authorized at least 140 people. But he performed that entire mission with only 103 people. Everything was done and we're grateful to him. They treat us as veterans at the VA clinic with kindness and respect. They have always made it a point to treat the veteran the way he feels he should be treated, with a little dignity, not as a welfare case. When we go down there, every one of us walk away, even though we might wait for the appointments, we walk away feeling good and know that somebody is concerned with our welfare.

The only recommendation that we have at this particular time is the fact that so many men are dying, that if you could make available hospital space in the local hospital, bed space in the local hospitals, now, so that if a veteran is sick he can at least go to a local hospital rather than being shipped to Tampa or someplace like that.

With that, I would turn it over to General Moench.

[The statement of Sam Moody appears at p. 119.]

Mr. EDGAR. Before we move to General Moench, let me just say we appreciate your statement. One of the architects of the legislation that you described is John Paul Hammerschmidt, who happens to be the right hand of Sonny Montgomery. I'm the left hand—on purpose, I guess. But John Paul has done a great job over the last several years in trying to look out for the needs of former prisoners of war and was instrumental in helping us get that legislation passed.

Mr. MOODY. It is the first time in many years that the POW's have been happy.

Mr. EDGAR. Are there any questions of this witness?

Mr. MCCOLLUM. I would just like to take the opportunity, Mr. Chairman, to comment that Sam Moody is one of the truly well-known, well-liked, well-respected individuals of all the veterans community around here, not that we don't have a lot of them already in the room.

But to give you an example of just how widely popular he has been in the past, I was over in Europe a few years ago, before I was elected to Congress, in Germany with my family—I'm a Kiwanian and I visited a Kiwanis Club over there that he helped found, I understand. So his reputation goes beyond our country even, and sometimes those of us don't always appreciate the other side besides

the military. He has given service in a broad sense. He did that, I believe, quite a number of year ago.

We are really appreciative of having your input, not that we aren't everybody else's. But I couldn't resist telling the chairman that story, Sam.

Mr. MOODY. Thank you, sir.

Mr. HAMMERSCHMIDT. Thank you, Mr. Moody.

Mr. EDGAR. Our final witness of the day is Maj. Gen. John Moench——

General MOENCH. It's pronounced "mench," like "don't mention it."

Mr. EDGAR. OK. I like that. He is with the U.S. Air Force, retired. We appreciate your patience today and we look forward to hearing your statement. The full text of your statement will be made a part of the record.

STATEMENT OF MAJ. GEN. JOHN MOENCH

General MOENCH. I will try to hold this down because I know the day gets long and everyone gets tired. I have been through too many hearings in Washington and I know what you all go through—when you don't need more of these long ones.

I am here not to make your task harder but to make it easier. I am here in an attempt to help avoid some mistakes. As you know, I only recently became involved in this particular testimony. I am not here representing an organization. I was called upon by quite a few people, organizations in the central Florida area, to combine thoughts and to make more meaningful their thoughts in a combined testimony. It so happened that at that time I was engaged with some cohorts in a very deep analysis of the military influence in the State of Florida in the past and looking to the future. Therefore, I had a statistical base that was very important to this hearing. The central Florida veterans drew on that statistical base and then, finally, reached the point where they said "Why don't you stand up and represent us."

Now, I must say that this problem of trying to get a total opinion is most difficult and I can appreciate the problems you go through to achieve this.

We have here in central Florida some 60 military veteran-kinds of units. When they turned to me and asked me to take on this task—John Piner, of the AMVET District No. 2, sitting right here, was the first one who voiced that. He was joined by Don Arthur of the Military Order of Foreign Wars, here somewhere; Sam Moody of the American Ex-Prisoners of War; John Combs of the American Federation of Ex-POW's; Hyman Bernstein of the Defenders of Bataan and Corregidor; Lou Krubel of the Air Force Association; Bill Mayor of VFW District 18, Harold Karp of the Jewish War Veterans; Harold Parker of the Reserve Officers Association; Bill Brown, Air Force Sergeants Association, and so forth. These are the veteran leaders of organizations, either presidents or commanders or the like.

They said, one, go ahead, and two, after consulting with them on everything I was going to say, which is in my statement, they said "we endorse what you are saying." So, in effect, while I am sitting

here I have the burden of looking at about 100,000 people on my shoulders, which worries me to no end. I have to be fair to all these people, and be fair also to the neighboring people. Because I don't like bias and I don't like any of the parochialisms that sometimes underlie arguments, I tried to get rid of that. As I told each one of them, "you are faceless as far as I'm concerned. When I look at you, you're a number in the statistical pool and let's see what the answer is that comes out of that pool."

Now, with respect to the emphasis on national organizations versus State organizations, and I know that question has been raised. I realize you generally focus on the national structure of an organization. You must realize, of course, that just as there are differences in Congress, there are differences in military organizations and quite often you will find a different view at the State level than you might find at the national level. This is only natural in the way people are oriented and organized.

A first point I would like to make to you is with respect to the VA projection of the veteran population in Florida. As of about 24 hours ago, I received some new statistics which would update the statement you now hold. One of the key indicators to show how people move is the rate at which the retiree moves to select States. That happens to be a very good statistic because in the defense system they know where those checks go by the ZIP code on them.

In fiscal year 1981 the military growth of retirees in Florida was 2.3 percent. Just the other night I got my new defense information in and that has jumped to 11.2 percent in fiscal 1982. That's a tremendous jump.

Now, I remind you that the veteran projection the VA was using, depending upon which paper you look at, is 12 percent or 15 percent or sometimes 17 percent for the decade. Now, the indications I have in our analysis is that, as people's choices go, they are reflected in the retired population—the veteran tends to move in about the same manner, from State to State.

Now, this means that potentially the 5,000 figure that has been used several times today is no longer 5,000. As you run out the statistical numbers taking that 11.2 percent of the retired population in fiscal year 1982 and using the normal spread between retired and veterans, you will find you are getting down here in Florida about 300 veterans a day or 6,000 a month. And 5,000 increasing to 6,000 is a significant jump when you're doing planning. I might say that my life has been in the planning business and I know how to interpret these numbers very quickly.

Also, we consider the transient population of veterans—the tourists or the "snow birds." If we take the normal tourist statistics of the State of Florida and use the conversion factor generally used by the State of Florida, which now produces the equivalent of 1 million permanent people per year, and then take the spread of veterans to total population, you will find that the tourist impact is the equivalent of having 125,000 additional permanent veterans in this State.

Finally, a point that no one has raised—I shouldn't say no one as it was raised in the past in many discussions—there was a fear—and this relates as an example to a State home—there was a fear voiced by many people—I sort of pooh-poohed it, but nonetheless

there was a reasonable fear here—that as you increase the veteran facilities in Florida, so you will increase the veterans coming to Florida. Now, the statistical analysis that we have made, crude as they are, because I've only got a couple of people around here and don't have computers to work with these things, the statistical analysis indicates that there are certain influences that significantly decide where people go. If you're in the military, one of those influences, and the first question you ask if you're retiring or moving, is "what are the medical facilities?" Right now you don't have to go very far to learn the medical facilities in Florida aren't very good.

That means as you correct, and you should correct, these medical deficiencies in Florida, these current projections of population increases are going to go haywire. As you bring the Florida veteran services up to the national level, you're going to find there is a pack of people who are going to come. That is going to create another set of deficiencies on top of the current deficiencies after the first ones are solved.

With respect to the central Florida VA Hospital siting, I do hate to add anything to that controversy. We have run out statistics as to where that siting should be. We have run these data several ways. We have used the VA data. We do come up—and I'm sorry if I tread on any toes on this—but we do come up with an Orange-Seminole location as being the center of the population and better serving the total community in total miles or time to service facilities. We do tend to focus on the University of Central Florida as a preferred site.

But there is another important aspect in all this. This morning we had a meeting with VA representatives. We told the VA that we knew the Commander at Patrick did not want to have a VA Hospital in his proximity because of the hurricane evacuation problem. We said to the VA analysts, "Have you considered the hurricane evacuation problem?" and they said "No, but what we will do is build a hurricane-proof hospital."

Well, I happen to know a little bit about that subject. No. 1, there isn't such a thing. No. 2, if you tried to build it, it would be so costly that you couldn't generate the money. I have been through too many typhoons in the Pacific and in hurricanes here. You don't want to raise the level of an evacuation problem by having to take hospital people out if you can avoid it.

I'm sorry I'm taking too long. Let me hurry.

With respect to——

Mr. EDGAR. I will give the gentleman 5 additional minutes.

General MOENCH. Thank you, sir.

With respect to innovation and solutions—and I have heard you call for that—I want to respond. I want to respond to it as a long-time military planner and economic planner, both U.S. and international. I know this frustration you're dealing with in trying to get adequate money to solve this thing, and I appreciate it.

I think, first off, we have got to seriously consider contracts. I have heard points raised that somehow or other the profit incentive is not good. I can't accept that because we are in a profit incentive environment. It's called capitalism. Our weapons systems

have profit in them. We don't try to build our own aircraft. That was long ago decided not to be practical.

I think, if you're looking for some sort of quick innovation, you have a proving ground here in Florida, with the massive number of veterans in it, to consider at least segments of that problem being handled by contracting. As an example—and we do have long distances to travel in Florida. Brevard County is a case in point. It is a long son-of-a-gun, north to south. It may be that the answer is not to have a controversy as to where the VA hospital is to be located but to go contract in the local area to one of the local hospitals. I am sure a contract solution can be provided. Put the VA hospitals more in a center of a given population, but handle some of this veteran health problem by contract. There is an opportunity in Florida a to try to do something new and innovative.

Now, let me say we need, as everyone has said, an answer now. I asked the VA people this morning, "What is the measure of your deficiency today in hospital beds? I don't want to hear of the 10 years down the road problem. What is it today?" The answer that came back, after they gave me some statistics and I ran them through the calculator—I said, "you mean today, against national standards, we are short in Florida 1,050 beds?" And they said "Yes." I said, "That's three major hospitals we are short today. That's a very, very big shortage."

A point that has not been raised, and I can speak to this from the military planning side because that has been my profession and my life, we have, unless somebody has burned them up, a lot of mobile hospitals in the war reserve. On occasion we have taken these mobile hospitals, when there has been overseas tragedy, and sent them out to aid foreigners. I would say, as an innovative solution, if we need a quick one—and we do need a quick one—we have mobile hospitals in the war reserve that are just sitting there. They are portable buildings, not tents of the World War I variety. They are portable buildings to be moved, with equipment, all sitting there unused. I certainly would explore the bringing out of those hospitals and putting them into service. That will be an immediate solution. It will take some money, but not as much money as building a whole hospital.

As to the chairman's point of view on working hospitals as opposed to the point raised of bringing in beds and putting them in the hallways, again, from the military planning point of view, I would prefer to have a working hospital. If we do get into a big war, there is not going to be any line between a civilian hospital and a military hospital; whatever is there will be used, the best we can. Sometimes we have people who in a parochial way lose sight of this. I think that is wrong.

Finally, if I have other innovative suggestions per your comments, I will come to you. Also, as a result of having been thrust into this, I will try to ease your load. Instead of dealing with so many individual organizations, I will try to hold together some cohesive thought for you on this subject in the central Florida area.

Finally, I would like to close on a point—and this may be humorous, but it is not really intended as humorous. I picked up in my mail yesterday—this in the Air Force Times magazine—an article that indicated the Government had solved the cemetery problem in

Florida. I am working to keep people alive, not bury them, and I hope this problem doesn't get buried.

[The statement of General Moench appears at p. 133.]

Mr. EDGAR. Thank you very much for your statement. We gave you an additional amount of time because of the comprehensive nature of your statement.

General MOENCH. I appreciate that.

Mr. EDGAR. As we indicated early on, the site selection information that you are gathering from all of your groups really must be the second step. The first step is getting the hospital identified for the 5-year plan, and the second step is convincing the administrative honchos in Washington particularly as to the most valuable site.

It isn't that we are not interested in site selection. We are interested in the pros and cons. But we don't have the technical ability or the staff capability of analyzing those sites. We do have the staff capability and analytical capability of analyzing the need based on population, population trends and demographics. The information which you have provided here and will provide in the future will be very helpful.

All three of you, I urge you to accept my challenge. In terms of the innovation, we have scratched the surface here today. I would like to commend my colleagues, the two "Bills", for staying and being patient with us. Often Congressmen who come to hearings have to get up and leave in the first half-hour because there is always a pressing appointment or an airplane to catch, but fortunately, your two local Congressmen from this area listened very carefully to the statements that were made, not only by the committee but, most importantly, by the witnesses who are here. I would just like to commend all of those who have testified.

General MOENCH. May I add one comment, sir?

Mr. EDGAR. The gentleman is yielded 30 seconds.

General MOENCH. We sincerely appreciate the support that we get from Congressman Nelson and Congressman McCollum. Frankly, the veterans here don't know what they would do without them.

Mr. EDGAR. I yield to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. General Moench, I am going to share something with you. You observed our chairman here and his polite and low-key demeanor. I want to tell you that he is also an ordained Methodist minister. Underneath all that, there is a little bit of a mischievous streak. If you notice your place on the agenda, he knows that sitting out there there have been a lot of airmen and a lot of soldiers, a lot of GI's, that always wanted to see a major general be last. He's taking it out on you. [Laughter.]

In all sincerity, we very much appreciate your patience and your expertise that you obviously have and the message that you brought us here.

General MOENCH. Sir, I always said to all of the enlisted men who worked for me, "I will never ask you to do anything I will not do myself."

Mr. HAMMERSCHMIDT. Yes, I'm sure that's true. I was being facetious, obviously. I still think they may get a kick out of it.

Mr. EDGAR. Let me take a moment to indicate that sitting next to me, to my left, is Jack McDonell, who is counsel for our staff,

and behind me is Rich Fuller, who is my personal staff person and a committee staff person for the House Veterans' Affairs Committee. We have Barbara Daniel here, who is one of our staff assistants in Washington.

There are also around us some staff people for the Congressmen here, for the Senator from the area, and from the VA. We have had other Congressmen, as I have mentioned, Buddy McCabe and Mike Bilirakis, Bill Young, Dan Mica, and Bob McEwen on this particular tour. Whenever you take that many crazy Congressmen out of Washington and spread them around the State, there are a lot of arrangements and technical problems that are involved. I would like to thank them.

I would also like to thank our recorder, who has come down from Washington to record today's hearing. The full text of this hearing will be made a part of a public record which will be available in printed form for people to see. It will be used as the basis for our final report which we will make toward the end of the year.

Mr. NELSON. Mr. Chairman, on that point, I had a request from a Mr. McGee of Orlando to submit a statement applying to—and I think it's going to be very laudatory of—the Tampa VA Hospital. So for him and others, if it would be permissible with the committee to keep the record open so that they may be inserted.

Mr. EDGAR. We will keep the record open for 2 weeks specifically, and the file will be open, as I indicated, through December and January to receive information for our final report. But the record of this hearing, we will give 2 weeks for specific comments, and if we need to expand that a little bit, we will do it with our judgment.

Thank you again, and thank all of you in the audience for your patience today.

This particular meeting of the House Subcommittee on Hospitals and Health Care stands adjourned.

[Whereupon, at 5:15 p.m., the subcommittee was adjourned.]

APPENDIX

PROPOSED TESTIMONY

Richard T. Crotty

State Representative - District #37

Chairman, Orange County Legislative Delegation

STATEMENT: "New construction of hospital beds should be in an area which would improve accessibility to inpatient care for the greatest number of veterans."

REBUTTAL: Population (Part I - ". . . greatest number of veterans.")

The Orange County Primary Service Area (PSA) will accommodate 8,318 more veterans than the Brevard County PSA according to September 1982 veteran population statistics.

According to figures supplied by the Veterans Administration Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida, the Orange County PSA would accommodate 9,860 more veterans than the Brevard PSA by 1995.

The VA's 1995 population projection allowed for an 18.8 percent increase in veteran growth for both counties. Yet, Orange County's average yearly projected growth to the year 2000 is almost 29 percent larger than Brevard County's growth projection. This growth differential would theoretically boost Orange County's Veteran population by 24 percent if Brevard's veteran growth is estimated to be 18.8 percent.

Brevard PSA - (Sept. 1982 VA figures)

Brevard	59,214
Indian River	7,300
Martin	5,630
Okeechobee	2,034
Orange	86,729
Osceola	5,085
St. Lucie	10,207
Seminole	20,401
Volusia	36,682
TOTAL	233,282

Orange PSA - (Sept. 1982 VA figures)

Brevard	59,214
Flagler	823
Indian River	7,300
Lake	13,125
Okeechobee	2,034
Orange	86,729
Osceola	5,085
St. Lucie	10,207
Seminole	20,401
Volusia	36,682
TOTAL	241,600

1995 VA population figures - Orange PSA = 287,050
Brevard PSA = 277,190

(above figures based on an 18.8% increase for both counties)

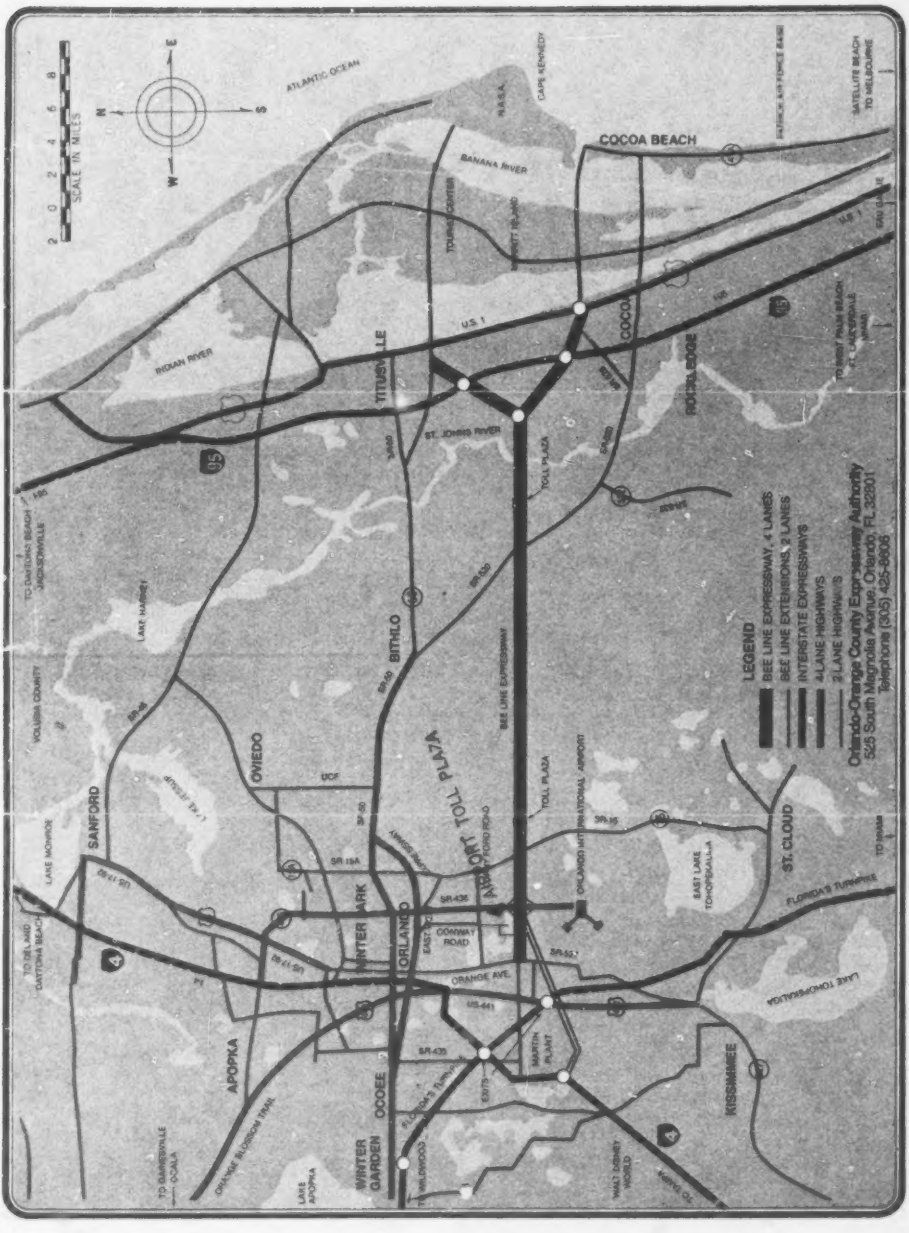
Projected county population growth - Univ. of Florida Statistical Abstract Report

Brevard
1985 - 291,900
1990 - 309,900
2000 - 349,200

Average yearly growth = 6.3%

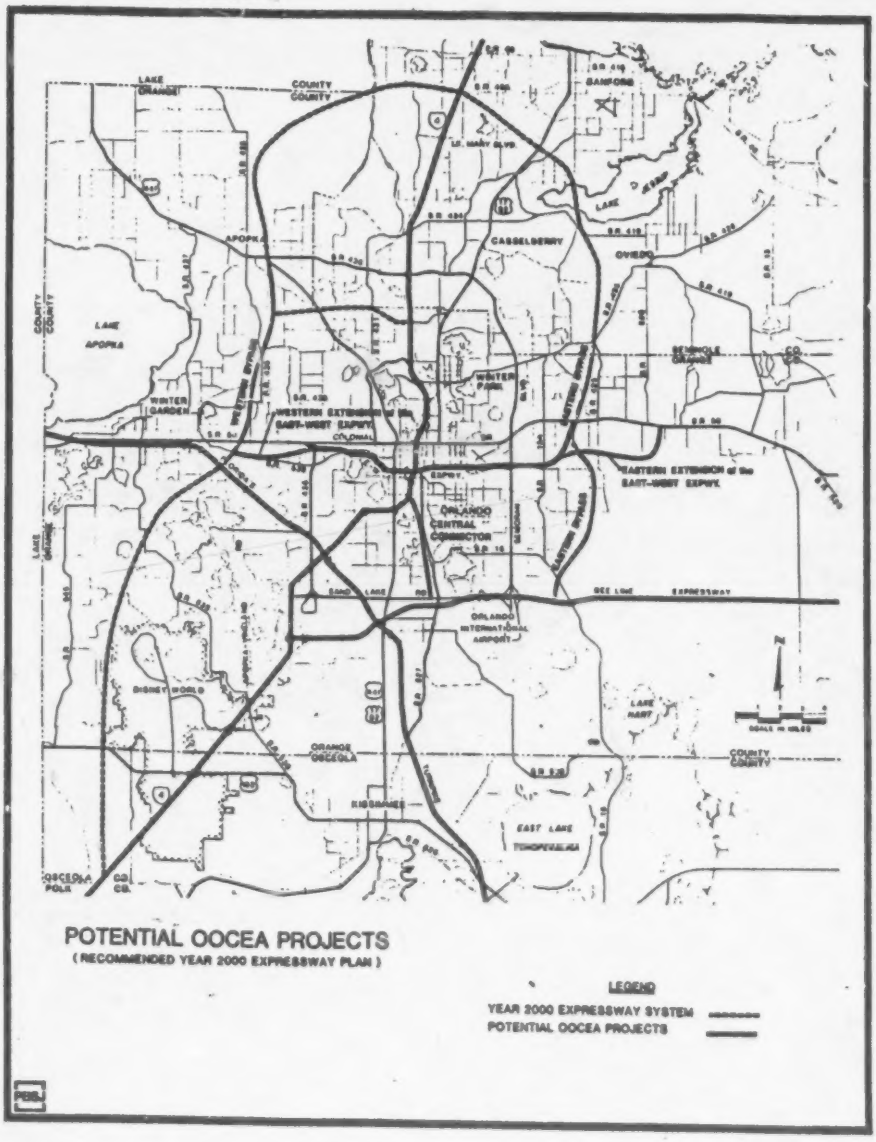
Orange
1985 - 527,700
1990 - 581,100
2000 - 668,700

Average yearly growth = 8.13%


COCOA BEACH
ATLANTIC OCEAN
BANANA RIVER
INDIAN RIVER
ST. JOHNS RIVER
TITUSVILLE
ROCKLEDGE
COCOA
SANFORD
OVIEDO
BITHLO
AIRPORT TOLL PLAZA
BEE LINE EXPRESSWAY
ORLANDO
WINTER PARK
APOPKA
OCOEE
WINTER GARDEN
ST. CLOUD
KISSIMMEE
LAKE TOHOPEKALIGA
EAST LAKE TOHOPEKALIGA
LAKE MONROE
LAKE MARY
ORANGE BLOSSOM TRAIL
FLORIDA'S TURNPIKE
U.S. 1
SR 50
SR 436
SR 434
SR 417
SR 528
I-95
I-4
SCALE IN MILES
LEGEND
BEE LINE EXPRESSWAY, 4 LANES
BEE LINE EXTENSIONS, 2 LANES
INTERSTATE EXPRESSWAYS
4-LANE HIGHWAYS
2 LANE HIGHWAYS
Orlando-Orange County Expressway Authority
525 South Magnolia Avenue, Orlando, FL 32801
Telephone (305) 425-9606

REBUTTAL: (Part II - ". . . in an area which would improve accessibility . . .")

Road Accessibility



REBUTTAL: Mileage Vicinity (Part III - ". . . area which would improve accessibility to inpatient care for the greatest number of veterans.")

According to 1982 mileage-versus-population statistics (both supplied by the VA), 64 percent of the veteran population within the Brevard County PSA live closer to the Orange County PSA.

Closest to Brevard County PSA (using only those counties located in Brevard PSA)

County	Population	Distance to Brevard PSA	Distance to Orange PSA
Brevard	59,214	0	46
Indian River	7,300	47	86
Martin	5,630	84	130
Okeechobee	2,034	70	94
St. Lucie	10,207	63	100
TOTAL	84,385 = 36% of the Brevard PSA total veteran population		

Closest to Orange County PSA (using only those counties located in Brevard PSA)

County	Population	Distance to Brevard PSA	Distance to Orange PSA
Orange	86,729	46	0
Osceola	5,085	41	20
Seminole	20,401	47	14
Volusia	36,682	62	44
TOTAL	148,897 = 64% of the Brevard PSA total veteran population		

STATEMENT: "New hospitals should be located at sites which would minimize the negative impact on the utilization of existing (or other planned) hospitals."

REBUTTAL: The importance of the statement is well taken when a VA hospital is so close in vicinity to another VA hospital that negative impact from the overlap would be substantial.

However, inpatient demand in Florida, unlike the rest of the nation, far exceeds available service. Thus, the statement should not be a factor because veteran population in Florida is large enough to compensate for any impact on the Gainesville and Tampa VA hospitals.

Veteran Supply and Demand Statistics (supplied by the VA Final Report)

I. Gainesville VA Hospital

? beds per 1000 vets.

Tampa VA Hospital

2.3 beds per 1000 vets.

II. Medical District 12, which includes Gainesville, Tampa, Orange and Brevard Counties, has only 19.1 beds per 1000 veteran applications.

Medical District 12

19.1 beds per 1000 veteran applications

III. Nation's Veteran Population by 1990

5% decrease

Florida's Veteran Population by 1990

12% increase

IV. Impact on Present VA Hospitals:

	Gainesville Discharges	Tampa Discharges
Brevard	13.4%	14.4%
Orange	20.5%	15.0%

Other Justifications for Building Proposed VA Hospital in Orange County PSA

1. One proposed site for the VA hospital would be in the Central Florida Research Park, next to the University of Central Florida (UCF). The VA hospital and UCF's College of Health, which teaches nursing and other health-related occupations, would be able to use this proximity to mutual advantage.

2. An approved VA Medical District Plan provides for construction of a 120-bed Nursing Home Care Unit in Orlando. This unit's proximity to the inpatient VA hospital is obvious when dealing with emergencies demanding transportation between facilities or fragility of health precludes anything but minimal traveling.

STATEMENT OF CONGRESSMAN CHARLES E. BENNET

Mr. Chairman, thank you for the opportunity to testify on the health care needs of Veterans in the State of Florida. I have reviewed the Veterans Administration's report entitled "A Thirty Year Study of the Needs of Veterans in Florida" as well as the Final Report of Future Bed Need and Potential Sites for New Veterans Administration Hospitals in Florida. These two studies clearly indicate that there is a serious shortage of Veterans Administration facilities in Florida. Now that this fact has been established, we must work together to make sure that the veterans of Florida are provided the appropriate medical care.

Many of the findings in these reports support my long held belief that the medical needs of Northeast Florida veterans would best be served by the construction of a Veterans Administration Hospital in Duval County. This area has one of the largest concentrations of retired military and active duty personnel of any metropolitan area in the nation. This concentration will continue to grow as the area's military bases continue their planned expansions.

Currently, Jacksonville has an Outpatient Clinic and no Veterans Administration Hospital. The nearest Veterans Administration Hospitals are in Lake City and Gainesville; a three hour round trip by automobile. As the average age of the veterans population increases and the demands of the system grow, I believe we must locate a Veterans Administration Hospital in the area of the primary concentration of Veterans. Having Veterans Administration Hospitals an hour and a half away from the state's third largest concentration of veterans does not make sense.

In short, I believe my long term feeling that veterans health care needs could best be served by the establishment of a Veterans Administration Hospital in Duval County is amply supported by the recent findings. I will continue to urge the Veterans Administration not to forget the urgent needs of the veterans of this area. I am encouraged by these hearings today as we must do everything possible to provide the proper medical care for those who sacrificed so much for their country.

September 8, 1983

STATEMENT BY CONGRESSMAN BILL MC COLLUM BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE COMMITTEE ON VETERANS AFFAIRS

Mr. Chairman, thank you for giving me the opportunity to participate in this field hearing of the Veterans Affairs Subcommittee on Hospitals and Health Care in an effort to assess the quality of health care for veterans in the VA's southeastern medical region and in Florida in particular.

It has been a little over a year since many of us who are here today discussed before this subcommittee the needs of veterans in Florida. Much has happened since that hearing on June 23, 1982, and we in Florida are extremely pleased that there has been a thirty year study report and that Administrator Walters has recently decided to construct a VA hospital in Palm Beach County. We are also pleased that the medical district plan covering much of Florida has made significant recommendations toward the future construction of many more beds and health care facilities for veterans in Florida before the year 2000.

However, while the thirty year study clearly documents the unique and critical nature of the Veterans Administration Health Service shortage in Florida now and in the coming years, the analysis, conclusions and recommendations flowing from the data provided by this study differ in many ways from my own analysis and conclusions and demonstrate how reasonable men may differ looking at the same set of facts.

The veterans population growth projections for Florida are significantly understated. According to government figures printed in today's Orlando Sentinel by the year 2000 Florida will be the third largest state in population in the United States, doubling its present population. It is reasonable to project a doubling of the veterans population in Florida in the same period of time. Using the study's own estimate that 41% of the Florida veteran population will be 65 years of age or older by 1990 and applying it to a more realistic veterans population growth projection one can readily see that the recommended increase in beds and additional health care facilities in Florida will fall far short of keeping pace.

The medical district plan and the thirty year study appear to premise their analysis and conclusions on a policy judgement that extreme caution should be used to avoid overbuilding and winding up with underutilized capacity after the year 2000 when the veterans population is projected to begin declining. As a result, the shortages of beds and facilities for veterans in Florida is likely to be even greater than would result simply from the underestimation of population growth.

The most serious defect I see in the study and in the district plan is the failure to adequately deal with and meet the presently existing and near-term shortages of health care, beds and facilities in Florida. Except for the West Palm

Beach hospital, the psychiatric beds and an effort to get started on nursing home facilities most of the construction of new beds and facilities would not be completed until well after 1990. The extreme shortage of beds in this state is clearly demonstrated when one contrasts the available bed usage here and elsewhere in the country. Veterans with service connected disabilities get bed priorities as well they should; however, in Florida they take up a much higher percentage of the total number of available beds than in any other part of the country which means that very few beds are available for the average veteran who would otherwise be entitled to them if he were living in another region of the country.

Despite the fact that we have a very large retired military population, the new Naval Hospital was designed only to serve the needs of the active duty military population of the area and even that is inadequately being served because of the extreme shortage of doctors and medical personnel in the Naval Service today with the obvious result that retired military in our area significantly add to the pressures for additional facilities that may be non-existent in other parts of the country.

Mr. Chariman, the veterans of Florida need relief now - not in 1995 or 2000 when demographic projections show many of them will have gone to their graves. Veterans of Florida need the timetable to be moved up dramatically from that appearing in the district plan and for stopgap alternatives

26-829 O—83——6

to be developed to provide them with the care that they are entitled to. Congress must allocate the necessary resources to do this if we are to avoid a national disgrace.

Now I realize that site selection for a new veterans hospital in the East Central Florida area is not the focus of this hearing, but I'm sure the committee members are aware that quite a controversy has developed in East Central Florida since the medical district plan gave a tentative recommendation of Brevard County over Orange and Seminole Counties for a recommended VA hospital to be constructed in the 1990s. You will hear more about this from many of the witnesses here today but I feel compelled to make a few brief comments.

Sometimes in the heat of the moment we forget the most important thing. The most important thing for East Central Florida veterans is that the plan recommends a hospital for East Central Florida. The next most important thing is that this recommendation is just that - a recommendation, - there is nothing final about any of this - not the site county; not even that East Central Florida will get a hospital at all.

In the coming months it is my fervent hope that everyone involved will work together to resolve differences of opinion with regard to the site selection and become united in our efforts to obtain a hospital as soon as possible for our distressed veterans area.

On the other hand, while I respect the judgement and hard work of those who worked on the district plan and recognize

that reasonable men may differ looking at the same facts, I strongly disagree with the site selection analysis in this plan and the conclusion that Brevard County is preferable to Orange or Seminole Counties. From the standpoint of reasonable access an appropriate location in either Seminole or Orange Counties is more central and accessible to many more veterans intended to be served than a location in Brevard. The central focal point of population growth and transportation in East Central Florida is Orange County, not Brevard. The state university for the area is in Orange County near the Seminole-Orange line and should a university medical facility ever be built in East Central Florida it would surely be the site. With a new Naval Hospital located in Orlando and knowing of the policy intent of Congress that facilities, equipment and personnel be blended and shared to as great an extent as practical between veterans and military hospitals it seems much more reasonable to place a new veterans hospital much closer to the Orlando Naval Hospital than could be possible in Brevard County. Worries about a hospital in Orange or Seminole County drawing significantly more patients away from already existing VA hospitals in Tampa or Gainesville moreso than a hospital in Brevard would do are unjustified and not a valid criteria to consider in deciding between Orange, Seminole and Brevard Counties. Either now or before reapportionment I have represented a high percentage of the areas presently serviced by both the Gainesville and Tampa hospitals as well as that which

would be served by a new hospital in East Central Florida and having much first-hand experience with veterans and their preferences as well as the geography and transportation systems of the area I feel my judgement on this point is as good or better than most.

It is my hope that the data and opinions gathered at this hearing today would lead to much constructive discussion among all interested parties in the local community, in the Veterans Administration and among the Members of Congress so that the long overdue attention to the critical veterans health care shortages in Florida can be addressed rapidly and appropriately. As to the specific issue of site selection should we be so blessed to gain a hospital in East Central Florida, I hope that all of the minds of those involved would remain open and that a calm and reasoned discussion of differing views on this matter can bring about a final decision that we can all be proud of and join in and support since we all share a common objective of providing adequate health care services to our veterans which is after all the bottom line of every bit of this.

Thank you, Mr. Chairman.

Prepared Statement

of

Major General Salvador E. Felices (USAF-Ret.)
Commissioner
State of Florida
Commission on Veterans' Affairs

Good Afternoon Gentlemen:

I bring you greetings from Governor Bob Graham and his personal apology/for his being unable to attend today's hearings. I also would like to welcome you/on behalf of the Florida Commission on Veterans' Affairs/ and the more than one and one-half million veterans that currently reside in our beautiful State.

Recognizing the fact that there are many others here today/ who wish to express their thoughts/ with respect to both the quality and quantity/ of available health care to veterans in Florida, my comments shall be rather brief.

As you probably know already, Florida is experiencing a rather pronounced growth/ in its population of resident veterans. With respect to the overall quality of health care available to veterans in our State, we have heard relatively few complaints. However, the quantity of available health care facilities is already below the national average and falling further behind each day. This is true in available beds per thousand veterans and in outpatient care.

In the recently published planning study "A Thirty Year Study of the Needs of Veterans in Florida," a study, by the way, with which the State of Florida concurs in principle insofar as it goes, we note some alarming facts. For instance, despite the fact that this study clearly indicates that Florida currently enjoys a lower ratio of available beds in VA hospitals than the rest of the Nation, no serious consideration is apparent to bring Florida to even a level of parity relative to the rest of our Country. It would be hard to

believe that in a State such as ours where rapid growth is so apparent in the overall and veteran population, that a lower ratio of available beds and outpatient care facilities will not worsen in the very near future. This trueism seems especially relevant when other factors presently known about Florida's veteran population are also considered.

Many of Florida's new resident veterans are of the age range that, according to VA reports such as "Health Characteristics of Veterans and Non-veterans," places the highest levels of demand for services in the VA health care delivery system. We believe that it is unreasonable to expect the level of available health care, provided by the VA in Florida, to remain on a level roughly equivalent with the rest of our Nation, since we already possess fewer resources to provide such care and future plans envision a maintenance of this deficiency.

With consideration given to these proposed problems, the Florida Commission on Veterans' Affairs would like to take this opportunity to go on record as supporting any currently proposed legislation that will allocate VA resources according to demographic data. Despite the apparent logic of providing care where it is needed most, as we would argue is the case with Florida, we believe that amending Title 38, United States Code, to reflect this logic is the only way in which Florida may be brought to parity with the rest of the nation and thus assure that the veteran population of this State is receiving at least the same health care as veterans in other States of the Union.

Along the same lines, we would also like to urge that serious consideration be given to applying this same rationale to areas such as the VA Department of Medicine and Surgery's program for granting funds to States for the construction of State nursing or domiciliary homes for veterans. At present, Florida has no such facilities and although we are currently in the process of trying to obtain such funding we have been informed that no such funds will be available for Florida until 1986. It appears that applications are processed on the basis of date of submission rather than need for the facilities. We believe that such funds should be allocated where they are needed most, rather than on the basis of the date of the application.

Following this same reasoning, we would note that Florida does not have access to a long-term VA psychiatric treatment facility in our State. As was noted in the previously mentioned VA study "Health Characteristics of Veterans and Non-veterans," nearly one-quarter of all VA hospital discharges on a national basis are for this type of treatment. We believe that the lack of such a facility for Florida represents a considerable hardship on those who require such treatment. At present, even though many mental health professionals agree that providing such treatment in the general proximity to the individual's family is beneficial, Florida must rely upon the availability of such treatment in other States, thus removing the chance of such family interaction during treatment. Although plans do exist for construction of such a facility in Florida in the future, we firmly believe that such plans should be expedited as much as possible.

In closing, I would like to make one other observation that has resulted from this Commission's recent experiences. As you may already be aware, Florida has taken considerable interest in the issue of Vietnam veterans in our criminal justice system. At the request of Governor Graham and members of the Florida Cabinet, our Commission has been attempting to investigate the incidence of criminal behavior in veterans and also to suggest possible alternative methods of treating this problem.

One such alternative that has been proven effective and practical has been the recent commutation of such an individual's sentence in order that he could attend a specialized program of counseling offered by the Bay Pines VAMC. This program is referred to as the "Vietnam Veteran Combat Unit". Although the results of such treatment would appear to be highly encouraging, the availability of entry into the program is highly restricted because of limited funding. It would be highly beneficial to recognize this new syndrome and provide adequate funds so that we can best understand the various psychological problems that affect our Nation's combat veterans so that we can predict and cope with them effectively. Treatment and knowledge of the cause of Post Traumatic Stress Disorder will be of great value in the future in terms of crime prevention and the restoration of an individual to be a member in good standing of our society. In any event, we would like to suggest that you assure that adequate funding is available for such programs and that, based upon the apparent need for such in-depth psychological counseling in Florida, we be considered for the establishment of another location for such treatment. Sixteen percent of Florida's population are veterans. Currently our veteran population is roughly one and one-half million strong and growing at a rate of over 5,000 new veterans moving to Florida each week. They have done their share. Now it's time for us to do ours.

On behalf of Governor Graham, the Commission on Veteran Affairs, and the Florida Veterans I thank you for allowing me to share these thoughts with you today.

STATEMENT OF
DONALD B. THOMPSON, DIRECTOR
SOUTHEAST REGION, DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS, HOUSE OF REPRESENTATIVES
THURSDAY, SEPTEMBER 8, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUB-COMMITTEE:

WE APPRECIATE HAVING YOU JOIN US IN MEDICAL DISTRICT 12 TO DISCUSS THE PROVISION OF HEALTH CARE SERVICES TO ELIGIBLE VETERANS IN THE STATE OF FLORIDA. I AM PLEASED TO HAVE THE OPPORTUNITY TO PROVIDE YOU WITH AN OVERVIEW AND TO RESPOND TO ANY QUESTIONS YOU MAY WISH TO POSE.

THE PRIMARY MISSION OF EVERY VA MEDICAL CENTER IS TO PROVIDE THE HIGHEST POSSIBLE QUALITY OF HEALTH CARE SERVICES TO OUR NATION'S VETERANS IN A COST-EFFECTIVE ENVIRONMENT. WE IN THE SOUTHEAST REGION AND IN FLORIDA ARE FIRMLY COMMITTED TO THIS MISSION.

IN FLORIDA, WE PROVIDE CARE THROUGH A NETWORK OF FACILITIES IN MEDICAL DISTRICTS 10 AND 12. DISTRICT 12 WHICH SERVES PENISULAR FLORIDA INLCUDES 5 MEDICAL CENTERS AT LAKE CITY, GAINESVILLE, TAMPA, BAY PINES, AND MIAMI AND 5 OUTPATIENT CLINICS AT JACKSONVILLE, ORLANDO, FT. MYERS, RIVIERA BEACH, AND OAKLAND PARK. THESE FACILITIES PROVIDE CARE TO VETERANS RESIDING IN 59 COUNTIES OF FLORIDA AND 19 COUNTIES IN SOUTH GEORGIA. THE EIGHT

COUNTIES OF THE FLORIDA PANHANDLE ARE SERVED BY MEDICAL CENTERS AT BILOXI, MISSISSIPPI, AND MONTGOMERY AND TUSKEGEE IN ALABAMA, AND THROUGH A SMALL OUTPATIENT CLINIC AT MOBILE, ALABAMA. IN ADDITION TO THE EXISTING FACILITIES, SATELLITE CLINICS HAVE BEEN APPROVED FOR PENSACOLA AND FOR DAYTONA BEACH. THESE ARE PLANNED FOR ACTIVATION DURING THE SUMMER OF 1985. FURTHER, THE ADMINISTRATOR OF VETERANS AFFAIRS HAS RECOMMENDED TO CONGRESS THROUGH THE FY 1984-1988 FIVE-YEAR FACILITY CONSTRUCTION NEEDS ASSESSMENT, THAT A NEW MEDICAL CENTER BE PLANNED FOR PALM BEACH COUNTY TO MEET THE INCREASING DEMAND FOR SERVICES IN THE SOUTH FLORIDA AREA. IF APPROVED AND AUTHORIZED BY CONGRESS, CONSTRUCTION OF THIS MEDICAL CENTER WILL BEGIN IN FY 1988.

THE FACILITIES SERVING FLORIDA VETERANS PROVIDE A FULL RANGE OF PRIMARY, SECONDARY, AND TERTIARY CARE THAT COMPARES FAVORABLY, IN QUALITY, TO THAT FOUND ANYWHERE IN THE HEALTH CARE INDUSTRY, PUBLIC OR PRIVATE SECTOR. THEY ARE AFFILIATED WITH 3 MEDICAL SCHOOLS IN FLORIDA AND REPRESENT URBAN, RURAL, LARGE AND SMALL ACUTE AND LONG-TERM CARE FACILITIES. THE MAJOR DEFICIENCY IN FACILITIES AT THIS TIME IS THE LACK OF A LONG-TERM NEUROPSYCHIATRIC CARE FACILITY, HOWEVER, PRESENT PLANNING CALLS FOR CONSTRUCTION OF A 290-BED ADDITION AT GAINESVILLE TO PROVIDE THIS SERVICE. THE PRESENT FIVE-YEAR CONSTRUCTION PLAN SHOWS THAT CONSTRUCTION WOULD BEGIN IN FY 87. IN THE INTERIM, THE LONG-TERM PSYCHIATRIC NEEDS OF OUR VETERANS ARE BEING MET LARGELY THROUGH THE FEE MEDICAL AND CONTRACT HOSPITAL PROGRAMS. FOR THIS AND OTHER REASONS, FLORIDA RANKS 4TH HIGHEST IN THE NATION IN FEE MEDICAL AND CONTRACT HOSPITAL EXPENDITURES.

CURRENTLY, THE VETERANS ADMINISTRATION IS AUTHORIZED TO OPERATE 3019 HOSPITAL BEDS AND 520 NURSING HOME BEDS TO SERVE THE NEEDS OF FLORIDA VETERANS. OUR CENTERS AND CLINICS EMPLOY 7,703 FULL-TIME EQUIVALENT EMPLOYEES AND THEIR COMBINED BUDGETS FOR FISCAL YEAR 1983 TOTALED MORE THAN $317 MILLION. IN ADDITION, THE FLORIDA MEDICAL CENTERS HAVE $6,185,284 IN VA-FUNDED RESEARCH, INCLUDING SIGNIFICANT INITIATIVES IN MEDICAL RESEARCH, REHABILITATION, AGENT ORANGE, AND HEALTH SERVICES RESEARCH.

THE 7,703 FULL-TIME EQUIVALENT EMPLOYMENT INCLUDES 1318 FTEE REGISTERED NURSES AND 416 FTEE PHYSICIANS. OUR MEDICAL SCHOOL AFFILIATES INCREASE OUR PHYSICIAN STAFFING LEVELS BY 186 FTEE WHO SERVE AS HOUSE OFFICERS. THE FLORIDA FACILITIES ARE FORTUNATE AT THIS TIME TO HAVE MINIMIZED NURSE RECRUITMENT AND RETENTION CONCERNS. PRESENTLY THERE IS A TOTAL OF 26 NURSE VACANCIES EXISTING WITHIN THE DISTRICT.

THIS FISCAL YEAR, THE MEDICAL CENTERS WILL ACCOMPLISH PROJECTS TOTALING $6,468,253 IN THE NON-RECURRING MAINTENANCE AND REPAIR PROGRAM. IN ADDITION, THEY RECEIVED $2,255,000 IN JOBS BILL FUNDING TO SUPPORT ANOTHER 24 PROJECTS IN THE STATE.

PRESENTLY, THERE IS AN ESTIMATED 1,442,240 VETERAN POPULATION RESIDING IN FLORIDA. 5.1 PER CENT OF THESE VETERANS ARE WOMEN. 1.8 PER CENT OF THE TOTAL SAW SERVICE DURING WWI, 46.3% FROM WWII, AND 27.2 PERCENT ARE VIETNAM VETERANS. THE OLDEST SURVIVING VETERAN OF THE SPANISH AMERICAN WAR IS A PATIENT AT THE BAY PINES NURSING HOME FACILITY.

AT PRESENT, 25.5 PERCENT OF THE VETERAN POPULATION ARE OVER 65 YEARS OF AGE AND, BY 1990, THAT PERCENTAGE IS EXPECTED TO INCREASE TO 41.2. THE VETERAN POPULATION FOR THE STATE IS EXPECTED TO CONTINUE INCREASING - PEAKING AT THE YEAR 2000 - AFTER WHICH IT IS EXPECTED TO DECLINE SLOWLY TO 1,280,000 BY THE YEAR 2010.

THE VETERANS OF FLORIDA ARE AVAILING THEMSELVES OF OUR SERVICES. DURING FISCAL YEAR 1983, WE EXPECT TO TREAT 70,627 INPATIENTS AND TO RECORD 873,355 OUTPATIENT VISITS. APPLICATIONS FOR MEDICAL CARE ARE EXPECTED TO TOTAL 165,789, EXCEEDING LAST YEAR'S LEVEL BY 7.1 PERCENT. THE PERCENTAGE OF VETERANS WHO ARE SERVICE-CONNECTED, AS OPPOSED TO NONSERVICE-CONNECTED, RECEIVING OUTPATIENT CARE, HAS INCREASED TO 68 PERCENT, RANKING THIS MEDICAL DISTRICT FIRST IN HAVING THE HIGHEST PERCENTAGE IN THE NATION.

WORKLOAD AND PRODUCTIVITY MEASURES SHOW THE FLORIDA MEDICAL CENTERS TO BE AMONG THE MOST ACTIVE IN THE SYSTEM. OVERALL, HOSPITALS ARE MAINTAINING AN OCCUPANCY RATE OF 80 PERCENT. OUTPATIENT WORKLOADS ARE EXCEEDING PLAN BY 6.7 PERCENT. EACH MEDICAL CENTER HAS APPOINTED A PHYSICIAN COORDINATOR FOR THE PRISONER OF WAR ASSESSMENT PROGRAM AND EACH IS PROCESSING AGENT ORANGE EXAMINATIONS ON A CURRENT, TIMELY BASIS.

FISCAL YEAR 1982 WAS THE FIRST YEAR OF THE DEPARTMENT OF MEDICINE AND SURGERY'S MEDICAL DISTRICT INITIATED PLANNING PROCESS (MEDIPP) WHICH IS A "GRASS ROOTS" POPULATION BASED PLANNING PROGRAM TO ASSESS THE HEALTH CARE NEEDS OF VETERANS. THE FIRST PLANS WERE COMPLETED IN NOVEMBER 1982 AND PROJECTED DISTRICT NEEDS THROUGH 1990. THE MEDIPP PLAN FOR MEDICAL DISTRICT 12 INDICATES A 15.7% INCREASE IN THE NUMBER OF VETERANS IN THE DISTRICT FROM 1980 TO 1990 AND PROJECTS A DRAMATIC 169% INCREASE IN VETERANS OVER THE AGE OF 65 DURING THE SAME PERIOD. THESE DATA POINT OUT THE IMPERATIVE TO MEET THE NEEDS OF OUR AGING VETERANS BY PROVIDING PLANNING FOR ADDITIONAL NURSING HOME CARE BEDS AND PROMOTING THE DEVELOPMENT OF NON-INSTITUTIONAL INNOVATIONS SUCH AS ADULT DAY CARE CENTERS, HOSPITAL BASED HOME CARE PROGRAMS, AND RESIDENTIAL CARE AS ALTERNATIVES TO INPATIENT BED CARE.

DURING FISCAL YEAR 1982 MEDICAL DISTRICT 12 COMPLETED A CONGRESSIONALLY MANDATED 30-YEAR STUDY OF VETERAN HEALTH CARE NEEDS IN FLORIDA WHICH IDENTIFIED A NEED FOR 1251 ADDITIONAL HOSPITAL BEDS TO CARE FOR THE VETERAN POPULATION WHICH IS EXPECTED TO CONTINUE TO GROW OVER THE NEXT 17 YEARS. 242 OF THESE NEEDED BEDS HAVE BEEN IDENTIFIED AS LONG-TERM PSYCHIATRIC AND SITED FOR GAINESVILLE AND MIAMI. A RECENT STUDY WAS ALSO UNDERTAKEN TO DETERMINE POTENTIAL SITES FOR THE REMAINING BEDS. THIS STUDY, WHICH CONTEMPLATED THE SUPPRESSED DEMAND AT EXISTING FACILITIES MODIFIED THE TOTAL BED NEED UPWARD TO APPROXIMATELY 1500. AS A RESULT OF THIS STUDY, A FACILITY OF 625 BEDS IN PALM BEACH COUNTY WAS IDENTIFIED AS THE PRIORITY SITE.

MEDICAL DISTRICT 12 HAS ALSO DEVELOPED PLANS TO MEET THE NURSING HOME NEEDS FOR 1990. THE PLANS ARE AS FOLLOWS:

VAMC	PROJECT	CONSTRUCTION PLAN YEAR
TAMPA	120-BED NHCU	FY 1982
LAKE CITY	120-BED NHCU	FY 1982
MIAMI	120 ADDITIONAL NHC BEDS	FY 1984
TAMPA	120 ADDITIONAL NHC BEDS	FY 1987
GAINESVILLE	120 ADDITIONAL NHC BEDS	FY 1988
LAKE CITY	120 ADDITIONAL NHC BEDS	FY 1988

THE 1982 PROJECTS AT TAMPA AND LAKE CITY AND THE 1984 PROJECT AT MIAMI ARE APPROVED AND FUNDED. THE LAST THREE PROJECTS ARE APPROVED BUT NOT YET FUNDED. WHEN COMPLETED, AT A COST OF APPROXIMATELY $456.2 MILLION, 680 BEDS WILL BE ADDED TO THE EXISTING 520, FOR A DISTRICT TOTAL OF 1200 NHC BEDS. FURTHER NURSING HOME NEEDS WILL BE MET BY ENCOURAGING THE STATE OF FLORIDA TO CONSTRUCT A STATE NURSING HOME FACILITY AND BY CONTRACTING FOR AN ADDITIONAL 900 BEDS IN COMMUNITY NURSING HOMES THE MEDICAL FACILITIES IN FLORIDA CONTRACT FOR 526 COMMUNITY NURSING HOME BEDS AT PRESENT.

THE HOSPITAL FACILITIES IN FLORIDA HAVE BEEN, OR ARE IN THE PROCESS OF BEING, UPGRADED. A LIST OF THE CONSTRUCTION PROJECTS TO BE ACCOMPLISHED IS ATTACHED. THE 19 MAJOR PROJECTS LISTED TOTAL APPROXIMATELY $531 MILLION IN CONSTRUCTION EXPENDITURES. BECAUSE OF TAMPA'S GROWTH AND LIMITED SPACE FOR EXPANSION, THE MEDICAL CENTER MUST ACQUIRE ADDITIONAL LAND TO ACCOMMODATE THEIR FACILITIES AND PARKING. THE INTENT IS TO PURCHASE A 16-20 ACRE PLOT DIRECTLY ADJACENT TO VA PROPERTY.

SINCE 1974 THERE HAS BEEN A 47 PERCENT INCREASE IN THE NUMBER OF INPATIENTS TREATED AND A 74 PERCENT INCREASE IN OUTPATIENTS TREATED IN FLORIDA. IN RECENT YEARS, HOWEVER, IT HAS BEEN NECESSARY TO LIMIT ACCESS TO CARE ON THE BASIS OF ELIGIBILITY PRIORITY GROUPS. CONSEQUENTLY, THE PERCENTAGE OF SERVICE-CONNECTED VETERANS TREATED AS OUTPATIENTS HAS RISEN 36 PERCENT SINCE FISCAL YEAR 1980; THE NATION AS A WHOLE EXPERIENCED ONLY A 2% INCREASE IN THE PERCENTAGE OF SERVICE-CONNECTED OUTPATIENTS TREATED.

THE PRIORITY OF SERVICE-CONNECTED VETERANS HAS CLEARLY RECEIVED EMPHASIS IN FLORIDA FACILITIES. MEDICAL DISTRICT 12 HAS THE NATION'S HIGHEST PERCENTAGE OF SERVICE-CONNECTED OUTPATIENTS TREATED AND RANKS SECOND IN PERCENTAGE OF VETERANS APPLYING FOR HOSPITAL CARE FOR SERVICE-CONNECTED CONDITIONS.

IN AN EFFORT TO RELIEVE DEFICIENCIES, I HAVE MADE FUNDING ADJUSTMENTS WITHIN THE SOUTHEAST REGION IN FISCAL YEARS 1982, 1983, AND 1984, WHICH WILL TOTAL $22.2 MILLION AND 252 FTEE (SEE ATTACHMENT B). OF THESE FTEE, APPROXIMATELY 120 WERE NURSES. THESE ADJUSTMENTS HAVE PROVIDED SOME RELIEF. THE DEPARTMENT OF MEDICINE AND SURGERY IS CURRENTLY DEVELOPING A RESOURCE REALLOCATION SYSTEM WHICH WILL SHIFT RESOURCES OVER A PERIOD OF 3 - 5 YEARS TO AREAS OF INCREASING DEMAND FROM AREAS WITH DECLINING WORKLOADS. CURRENT PLANNING CALLS FOR IMPLEMENTATION OF THIS PROGRAM WITH THE FISCAL YEAR 1985 BUDGET.

OTHER ACTIVITIES ARE BEING IMPLEMENTED TO IMPROVE EFFICIENCY IN OPERATIONS AND IMPROVE OUR ABILITY TO RESPOND TO PATIENT CARE NEEDS. AN EXAMPLE OF SUCH A PROGRAM IS OUR DECENTRALIZED HOSPITAL COMPUTER PROGRAM IN WHICH EVERY MEDICAL CENTER WILL RECEIVE COMPUTERS, BEGINNING IN JANUARY 1984, TO HANDLE CORE FUNCTIONS OF PATIENT ADMISSION, TRANSFER AND DISCHARGE, AND PHARMACY. FURTHER APPLICATIONS WILL BE IMPLEMENTED LATER IN FISCAL YEARS 1984 AND 1985 GIVING THE DISTRICT AUTOMATED DATA PROCESSING CAPABILITY NEVER BEFORE AVAILABLE IN THE VETERANS ADMINISTRATION.

THIS CONCLUDES MY FORMAL REMARKS. I WISH TO EXPRESS MY APPRECIATION TO THE SUB-COMMITTEE FOR THIS OPPORTUNITY TO DISCUSS THE VETERANS ADMINISTRATION HEATLH CARE IN FLORIDA. MY COLLEAGUES AND I WILL BE PLEASED TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

ATTACHMENT A

SOUTHEASTERN REGION
RECENT AND FUTURE MAJOR CONSTRUCTION PROJECTS

VAMC	PROJECT	CONSTRUCTION PLAN YEAR	ESTIMATE
MIAMI	RESEARCH & EDUCATION, PSYCHIATRIC ADDITION	COMPLETED NOVEMBER 1982	$11,597,000
BAY PINES	REPLACEMENT HOSPITAL	COMPLETED JUNE 1983	63,712,000
BAY PINES	REPLACEMENT HOSPITAL ALTERATION TO BLDGS 1 & 22	ONGOING: COMPLETED BY DECEMBER 1985	11,330,300
GAINESVILLE	CLINICAL IMPROVEMENT, RESEARCH & EDUCATION	COMPLETED JUNE 1983	19,596,000
TAMPA	120 BED NURSING HOME CARE UNIT	FY 1982	5,600,000
LAKE CITY	120 BED NURSING HOME CARE UNIT	FY 1982	4,700,000
MIAMI	OUTPATIENT ADDITION/ SCI RELOCATION	FY 1982	49,000,000
LAKE CITY	OUTPATIENT AND CLINICAL ADDITION	FY 1984	5,200,000
MIAMI	120 BED ADDITIONAL NHC BEDS	FY 1984	7,100,000
TAMPA	RADIATION THERAPY UNIT	FY 1985	8,500,000
GAINESVILLE	290 BED PSYCHIATRIC FACILITY	FY 1986	66,000,000
TAMPA	CLINICAL ADDITION/SCI ADDITION	FY 1986	43,000,000
TAMPA	120 BED NURSING HOME CARE UNIT (ADDITION)	FY 1987	11,000,000
MIAMI	RESEARCH ADDITION TO R & E BUILDING	FY 1987	7,200,000
PALM BEACH COUNTY	NEW HOSPITAL	FY 1987	186,000,000
MIAMI	WAREHOUSE EXPANSION	FY 1987	3,800,000
TAMPA	RESEARCH ADDITION	FY 1988	5,100,000
GAINESVILLE	120 BED NHCU (ADDITION)	FY 1988	11,500,000
LAKE CITY	120 BED NHCU (ADDITION)	FY 1988	11,500,000

26-829 O—83——7

ATTACHMENT B

SOUTHEASTERN REGION
MAJOR FUNDING ADJUSTMENTS - DISTRICT 12
FY 82, FY 83, AND FY 84 (TARGET ALLOW.)

	BAY PINES	GAINESVILLE	LAKE CITY	MIAMI	TAMPA
FY 1982	$ 2,515,612	$ 375,325	$ 48,209	$ 3,958,755	$ 767,477
FY 1983	5,355,391	629,124	334,370	5,625,193	2,495,695
FY 1984	87,000	-0-	-0-	340,000	-0-
GRAND TOTAL	7,958,003	1,004,449	382,579	9,617,948	3,263,172
DISTRICT GRAND TOTAL	$22,226,151				

Medical Center Bay Pines FL 33504

Veterans Administration

September 28, 1983

In Reply Refer To: 516/00

Mr. Donald B. Thompson
Regional Director (10BA3/G)
Southeastern Region
Veterans Administration
3456 S.W. 42nd Avenue
Gainesville, FL 32608

SUBJ: Data Requested of Bay Pines, VAMC by Members of the Subcommittee on Hospitals and Health Care, Veterans Affairs Committee

1. Attached are copies of data requested by Congressmen John Paul Hammerschmidt and Michael Bilirakis of the Subcommittee on Hospitals and Health Care of the United States House of Representatives Veterans Affairs Committee. Congressman Hammerschmidt made his request during the informal hearings held by the Subcommittee in New Port Richey, Florida on September 6, 1983. Congressman Bilirakis requested the population projection both before and during his visit to Bay Pines on September 7, 1983.

2. Please review and forward these data as appropriate. Information requested of all medical center directors in Florida by Subcommittee Chairman Bob Edgar at the Orlando hearing will be forwarded under separate cover as requested in the Regional Director's Conference Call of Sept. 20, 1983.

3. Thank you for your assistance in this matter.

RICHARD F. McELLIGOTT
Director
Medical Center

Enclosures: 2

Congressman John Paul Hammerschmidt requested the number of Outpatient Visits at Bay Pines, Gainesville, and Tampa.

HAS
FM
RD
SEC'Y

OUTPATIENT MEDICAL CARE

	BUDGETED FY82	ACTUAL FY82	BUDGETED FY83	ESTIMATED FY83
BAY PINES	85,216	87,704	108,094	106,270
FT MYERS	25,149	25,889	25,000	26,946
ST. PETERSBURG (Outpatient Clinic)[a]	55,772	56,590	33,043	39,534
TOTAL	166,137	170,183	166,137	172,750
TAMPA (including Orlando Outpatient Clinic)	186,708	196,565	201,000	214,000
TOTAL	186,708	196,565	201,000	214,000
GAINESVILLE	93,285	84,547	84,679	90,752
JACKSONVILLE (Outpatient Clinic)	50,000	41,922	39,664	38,304
TOTAL	143,285	126,469	124,343	129,056

[a]Ambulatory Care Clinic consolidated with Bay Pines - June 1983

Attachment 1

Congressman Michael Bilirakis requested the number of veterans both current and projected for Pasco County.

COUNTY	MARCH 1983	1990
Pasco	32,470	34,020

This current and projected veteran population data was prepared by the Office of Reports and Statistics (70), VA Central Office in April 1983.

ATTACHMENT 2

Southeastern Region

3456 S.W. 42nd Avenue
Gainesville FL 32608

Veterans Administration

October 24, 1983

In Reply Refer To: 10BA3/G

Honorable Robert W. Edgar
House of Representatives
Washington, D.C. 20515

Dear Mr. Edgar:

We are pleased to have this opportunity to respond to a couple of important questions you asked me and the Florida Medical Center Directors at the Subcommittee's hearings in Orlando, Florida on September 8, 1983.

Question:

What are the three things you are most proud of in your institutions?

Florida Responses:

VAMC Bay Pines: 1. The staff who provide medical care to the veterans in a caring, conscientious and dedicated manner; 2. The volunteers who give so willingly of their time to assist the Medical Center in providing quality care to veterans; 3. The new ultra-modern hospital, domiciliary and nursing home facilities which provide an outstanding environment in which to serve veterans.

VAMC Gainesville: 1. The quality and dedication of the staff, their competence and professionalism; 2. The quality and strength of their affiliation with the University of Florida; 3. The reputation the Medical Center has in the community and the area it serves.

VAMC Lake City: 1. The ability and resources to upgrade and modernize the facilities; 2. A quality and productive research department; 3. The Medical Center's implementation and management of a Quality Assurance Program.

VAMC Miami: 1. The great amount of patient workload provided and the high productivity accomplished with limited staffing; 2. The Extended Care Program: intermediate bed section, rehabilitative bed section, nursing home care unit, hospital based home care, community nursing homes and residential care homes; 3. A very large and well run outpatient care program (including two satellite clinics).

VAMC Tampa: 1. Achievement of innovative and clinically relevant patient care programs; 2. The cost containment techniques used to maintain and expand clinical programs; 3. The achievement of many education programs and the affiliation with the University of South Florida.

Question:

What are the three things you are least proud of within your institution?

VAMC Bay Pines: 1. The limited resources resulting in less care available to Florida veterans when compared to national levels of availability; 2. The antiquated psychiatric facilities (Although an ongoing renovation will correct this situation, completion of the project is two years away). 3. The lack of highly qualified physician staff, particularly in specialty areas.

VAMC Gainesville: 1. The insufficient personnel and funds to meet the demands of the veterans needing care; 2. Because of limited resources, they are forced to apply a priority system (due to regulations) in caring for patients; 3. An inadequate physical plant having too many space deficiencies.

VAMC Lake City: 1. The absence of sufficient staff to enhance their patient care mission; 2. Their inability to sustain a pulmonary rehabilitation program due to insufficient resources; 3. Inadequate funding to support the outpatient workload and the denial of needed medical follow-up to a large percentage of our veterans.

VAMC Miami: 1. The lack of staff causing delays in delivering medical care in some areas; 2. The lack of adequate funding for both inpatient and outpatient programs limits the introduction of new programs and procedures; 3. The space restrictions causing overcrowding of patient care areas and poor working conditions for staff.

VAMC Tampa: 1. Physical facilities are insufficient and land limitations are restricting facility growth; 2. Inadequate funding to support the costs associated with tertiary care programs; 3. The restriction on acquiring new equipment and the concomitant space unavailability from having modern patient care capabilities.

In addition to providing the responses from the Florida medical centers, I am using this opportunity to list the three most frequently occurring responses from all the Southeastern Medical Centers.

Question:

What are the three things you are most proud of in your institutions?

VA Medical Centers, Southeastern Region, collectively:

1. The quality, dedication, and productivity of medical center staff and personnel; 2. The improvement, upgrading, and modernization of facilities; 3. The affiliations with the medical schools and resultant benefits.

Question:

What are the three things you are least proud of within your institutions?

VA Medical Centers, Southeastern Region, collectively:

1. The lack of sufficient resources to treat all of the nonservice-connected veterans presenting themselves for care and the general inability to meet the unmet demand for health care needs; 2. The lack of facilities improvement, the space deficiencies in which to provide medical care, and the poor working conditions for staff and personnel; 3. The insufficient staffing to meet the medical care demands of the veterans.

Thank you for the opportunity to provide this information to you. I hope it will be of some benefit to your committee.

Sincerely,

Donald B. Thompson

DONALD B. THOMPSON
Director
Southeastern Region

STATEMENTS BY HARRY F. McDOWELL
STATE COMMANDER - FLORIDA AMERICAN LEGION

MR. CHAIRMAN -
DISTINQUISHED MEMBERS OF THE SUB-COMMITTEE ON HOSPITALS AND HEALTH CARE OF THE HOUSE COMMITTEE ON VETERANS AFFAIRS;

WE, OF THE FLORIDA AMERICAN LEGION, THE STATES LARGEST VETERANS ORGANIZATION, WELCOME THE OPPORTUNITY TO PRESENT TO YOU THE AREAS OF OUR CONCERN DEALING WITH THE HEALTH CARE AND DELIVERY OF HEALTH CARE SERVICES TO THE STATE OF FLORIDA.

WE ARE PARTICULARLY PLEASED THAT MEMBERS OF THIS COMMITTEE WHO DO NOT RESIDE IN THE SUN BELT HAVE TAKEN TIME TO COME TO THE SUNSHINE STATE TO LEARN, FIRST HAND, THE SEVERITY OF THE PROBLEMS FACING THE VETERANS OF THIS STATE.

THE MOST OBVIOUS OF THESE PROBLEMS IS THE TREMENDOUS INFLUX OF VETERANS THAT COME TO THE STATE OF FLORIDA ON A SEASONAL BASIS, AS WELL AS THOSE WHO ARE CONTINUALLY MOVING TO THE SUNSHINE STATE ON A PERMANENT BASIS.

THE ESTIMATES OF THE VETERANS ADMINISTRATION CURRENTLY STATE THAT THERE ARE BETWEEN THREE AND FIVE THOUSAND VETERANS WHO MOVED TO THE STATE OF FLORIDA ON A PERMANENT BASIS, PER MONTH.

IT IS OUR UNDERSTANDING THAT THIS IS THE NUMBER OF VETERAN ADMINISTRATION FILES THAT ARE TRANSFERRED ON A MONTHLY BASIS. THIS DOES NOT ACCOUNT FOR THOSE VETERANS WHO DO NOT HAVE CURRENT, ACTIVE FILES WITH THE VETERANS ADMINISTRATION. THUS, THE NUMBER OF VETERANS

AND THEIR FAMILIES MOVING TO THIS STATE IS CONSIDERABLY GREATER THAN THESE ESTIMATES.

FOR THOSE OF US WHO RESIDE HERE, IT CERTAINLY CREATES A MONUMENTAL PROBLEM. UNFORTUNATELY, THE FEDERAL BUREAUCRACY AND REACTION TIME OF THE GOVERNMENT TO THESE TYPES OF SHIFTS OF POPULATION, ARE GAUGED IN YEARS, AND THE REACTION TIME OF FEDERAL AGENCIES FOR THESE TYPE OF ADJUSTMENTS TAKE SO LONG THAT IN DEPTH PRE-PLANNING IS NECESSARY TO MEET CURRENT AND PROJECTED NEEDS.

WITH THE EVER INCREASING VETERAN POPULATION AND THE INCREASING AGE OF THE WWII VETERAN, IT IS OBVIOUS THAT THE VETERANS ADMINISTRATION MEDICAL SERVICES WILL BE FACING MONUMENTAL GROWTH IN THE STATE OF FLORIDA, FOR AT LEAST THE NEXT TWENTY YEARS.

AS WE ALL KNOW, THROUGH THE AGING PROCESS, MORE MEDICAL CARE IS NEEDED. THE WWII VETERAN IS NOW FACED WITH THIS INCREASED MEDICAL ATTENTION. IT IS THE RESPONSIBILITY OF THE VETERANS ADMINISTRATION TO PROVIDE ADEQUATE SERVICES FOR THOSE WHO HAVE BORN THE RESPONSIBILITY OF DEFENDING THIS COUNTRY.

WE WOULD LIKE TO ADDRESS THE CURRENT STATUS OF THE OUT-PATIENT CLINICS, AS THEY CURRENTLY EXIST IN THE STATE OF FLORIDA. WE ARE FORTUNATE IN THE STATE OF FLORIDA, THAT THE FIVE OUT-PATIENT CLINICS THAT ARE CURRENTLY OPERATIONABLE, ARE MANNED BY DEDICATED INDIVIDUALS

WERE IT NOT FOR THESE VETERANS ADMINISTRATION EMPLOYEES, ACTIVELY ATTEMPTING TO SERVE THE VETERANS WITHIN THEIR GEOGRAPHICAL BOUNDARIES, THE VETERANS OF THIS STATE WOULD CERTAINLY BE SHORT CHANGED!

I BASED THESE REMARKS ON THE FACT THAT THREE OF THE FIVE CLINICS IN THE STATE OF FLORIDA, HAVE ALREADY EXCEEDED THEIR BUDGETED CAPACITY FOR VETERANS VISITS, AND WE ARE ONLY IN THE TENTH MONTH OF THE FISCAL YEAR. AS AN EXAMPLE, ON A PROJECTED BASIS, THE RIVIERA BEACH FACILITY IS BUDGETED FOR 46,000 VETERAN VISITS, AND IN FACT, THE CURRENT PROJECTIONS ARE THAT THE CLINIC WILL HAVE IN EXCESS OF 55,600 VETERANS VISIT, THIS FISCAL YEAR.

THE OAKLAND PARK FACILITY IS BUDGETED FOR 65,700 VETERAN VISITS, AND IN FACT, PROJECTIONS INDICATE THEY WILL HAVE IN EXCESS OF 68,700 VETERANS VISIT THE FACILITY.

THE FORT MYERS CLINIC, WHICH IS CLOSEST TO MY HOME, IS BUDGETED FOR 25,000 VETERAN VISITS, AND PROJECTIONS INDICATE THAT AN EXCESS OF 30,200 VETERANS WILL VISIT THIS CLINIC.

THE TWO REMAINING CLINICS THAT ARE NOT PROJECTED TO EXCEED THEIR BUDGETED VISIT CAPACITY, ARE HOWEVER, GOING TO BE UPWARDS OF 95% OF THE BUDGETED PROJECTION. THIS DOES NOT LEAVE ANY LATITUDE FOR FUTURE GROWTH. IT IS IMPERATIVE THAT ADEQUATE BUDGET INCREASES BE ALLOWED FOR THESE FACILITIES AND THAT THEY BE IMMEDIATELY PLANNED FOR. WE WOULD ENCOURAGE THAT MORE OUT-PATIENT CLINICS BE ESTABLISHED WITHIN THE STATE OF FLORIDA TO MEET THE EVER INCREASING NEEDS OF VETERANS.

WITH THE OUT-PATIENT CLINICS BEING ONE OF THE PRIMARY ENTRY LEVELS FOR EXISTING MEDICAL CENTERS, THE OUT-PATIENT CLINICS HAVE REFERRED ALMOST 3,000 VETERANS FOR CARE THAT THE OUT-PATIENT CLINIC CANNOT PROVIDE. IT IS OUR OPINION THAT THIS IS ALSO AN INDICATOR OF THE NEED FOR MORE AND LARGER OUT-PATIENT FACILITIES AS WELL AS MORE HOSPITALS.

AS AN ORGANIZATION, WE DO NOT FEEL THAT IT IS OUR PURPOSE HERE TODAY, TO SITE INDIVIDUAL PROBLEMS THAT INDIVIDUAL VETERANS HAVE HAD WITH ANY PARTICULAR OUT-PATIENT CLINIC IN THE DELIVERY OF SERVICE.

AS AN OVERALL FUNCTION OF THE AGENCY, WE FEEL THAT THE OUT-PATIENT CLINICS AND MEDICAL CENTERS, ARE DOING A TREMENDOUS JOB IN THE DELIVERY OF SERVICE TO THE VETERANS OF STATE.

WE IN THE VETERANS COMMUNITY OF THE STATE OF FLORIDA, FEEL THAT WE HAVE AN OUTSTANDING RAPPORT WITH THE VETERANS ADMINISTRATION PERSONNEL.

WE WOULD ALSO BRING TO THIS COMMITTEE'S ATTENTION THAT MEDICAL DISTRICT 12, WHICH COMPRISES A PORTION OF GEORGIA AND THE MAJORITY OF THE STATE OF FLORIDA, CURRENTLY HAS THE HIGHEST PERCENTAGE OF NON-DISCRETIONARY VISITS OF ANY OF THE MEDICAL DISTRICTS. THE 12th MEDICAL DISTRICT IS CURRENTLY RUNNING AT A 73% NON-DISCRETIONARY VISIT BASIS COMPARED TO THE OVERALL VETERANS ADMINISTRATION TOTAL OF 55% NON-DISCRETIONARY VISITS.

THIS CERTAINLY IS A REALISTIC GAUGE TO THE WORKLOAD THAT IS PLACED UPON THE MEDICAL PERSONNEL OF THE VETERANS ADMINISTRATION.

THE FLORIDA AMERICAN LEGION HAS BEEN INSTRUMENTAL IN OBSERVING AND PARTICIPATING IN "THE 30 YEAR STUDY OF THE NEEDS OF THE VETERANS OF THE STATE OF FLORIDA".

WE WOULD LIKE TO COMMEND MR. MALCOLM RANDALL FOR THE INTERACTION THAT THIS ORGANIZATION HAS HAD IN THE PLANNING PROCESS THROUGH THE "MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP)". WE FEEL THAT THE "30 YEAR STUDY" AS AN OVERALL DOCUMENT IS A REALISTIC PLAN FOR THE FUTURE NEEDS OF THE VETERANS OF THE STATE OF FLORIDA.

WE ALL REALIZE THAT THERE WILL BE A TREMENDOUS INCREASE IN THE NEED FOR MEDICAL FACILITIES IN THIS STATE FOR THE NEXT TWENTY YEARS.

THE MEDICAL DISTRICT PLAN CURRENTLY PROJECTS THE NEED FOR 726 ADDITIONAL HOSPITAL BEDS IN MEDICAL DISTRICT 12 BY 1990. THIS IS AN IMMEDIATE SITUATION THAT MUST BE DEALT WITH NOW.

ALTHOUGH WE ARE IN NEED OF ADDITIONAL HOSPITAL BEDS IN THE STATE OF FLORIDA, ESPECIALLY WHEN OUR VETERAN RATIO IN THE CENTRAL AREA OF THE STATE, IS ONLY 2.3 VETERANS PER1,000 POPULATION, AND THE SOUTHERN PORTION OF THE STATE IS FACED WITH A 1.5 BED PER 1,000 POPULATION COMPARED TO A NATIONAL AVERAGE OF 3 BEDS PER 1,000 POPULATION. THIS IS CERTAINLY AN INDICATOR OF THE SEVERITY OF THE NEED FOR EXPANSION OF THE FACILITIES IN THE STATE OF FLORIDA.

ONE CONCEPT THAT HAS BEEN PROPOSED, THAT IS AN ALTERNATIVE TO EXPANSION OF BED FACILITIES FOR DOMICILIARY CARE WOULD BE A WISE

MOVE AND GOOD USAGE OF FEDERAL DOLLARS. THIS IS TO INVESTIGATE AND TO EXPAND INTO THE CONCEPT OF THE ADULT DAY CARE CENTER.

MANY VETERANS THAT WILL NEED DOMICILIARY CARE IN THE FUTURE WOULD FIT INTO A CATEGORY THAT WOULD BE CONDUSIVE TO AN ENVIRONMENT OF A DAY CARE CENTER WHERE THEY COULD HAVE SUPERVISION DURING THE DAY, AND BE ABLE TO RETURN HOME TO BE WITH FAMILY MEMBERS DURING THE TIME THAT THE MEMBERS OF THEIR FAMILY WOULD BE AT HOME. THIS CONCEPT IS BOUND TO BE A MAXIMUM USAGE OF THE DOLLAR FOR THOSE INVOLVED WITHIN THE PROGRAM.

THE AMERICAN LEGION HAS GONE ON RECORD AS ENDORSING THIS AS A MOST REALISTIC AND WORKABLE PROPOSAL. THIS ORGANIZATION ALSO FEELS THAT THE CONCEPT OF HOSPITAL BASED HOME CARE PROGRAM IS AN IDEAL USE AND FORMAT FOR NECESSARY CARE OF THOSE VETERANS IN NEED.

THESE PROGRAMS HAVE BEEN IMPLEMENTED, IN THE STATE OF FLORIDA, AND WE FEEL THEY ARE PROVING TO BE SUCCESSFUL. OVERALL, WE FEEL THAT THERE ARE ALTERNATIVE METHODS OF CARING FOR VETERANS IN THE STATE, OTHER THAN PLACING THEM IN VETERANS ADMINISTRATION MEDICAL FACILITIES.

WE WOULD ENCOURAGE THIS COMMITTEE TO SEEK OUT THIS TYPE OF ALTERNATIVE CARE FOR VETERANS. PARTICULARLY HERE IN THE SUNBELT AREA.

WE WOULD LIKE TO CONCLUDE THIS PRESENTATION WITH A STATEMENT REGARDING OUR FUTURE NEEDS IN THE AREA OF NEW MEDICAL FACILITIES. OBVIOUSLY THE NEED IS GREAT AND WILL BECOME GREATER IN THE FUTURE. A NEW MEDICAL CENTER IN SOUTH FLORIDA IS NEEDED AND IN THE PLANNING STAGES.

CENTRAL FLORIDA IS ALSO UNDER CONSIDERATION, AND I ASSUME YOU, THE AMERICAN LEGION, WILL ACTIVELY PARTICIPATE IN SUPPORTING THIS FACILITY. WE WOULD HOPE THAT THESE FACILITIES WILL BE PLACED IN LOCATIONS THAT ARE MOST BENEFICIAL TO THE DEMOGRAPHICS OF THE VETERAN POPULATION.

IT WILL TAKE A UNITED EFFORT ON THE PART OF THE VETERANS ORGANIZATIONS AND THE CONGRESSIONAL DELEGATION TO ENSURE THE VETERANS OF FLORIDA ARE SERVED PROPERLY.

WE AGAIN WANT TO SINCERELY THANK THE MEMBERS OF CONGRESS FOR TAKING THE TIME TO COME TO FLORIDA TO LISTEN TO OUR POSITIONS IN THIS MATTER. WE ARE ESPECIALLY PROUD OF CONGRESSMAN DAN MICA, WHO IS A MEMBER OF THIS COMMITTEE, WHO HAS DONE A TREMENDOUS JOB ON BEHALF OF THE VETERANS OF THE STATE OF FLORIDA.

WE ALSO WISH TO RECOGNIZE AND COMMEND AN INDIVIDUAL, WHO ALTHOUGH HE IS A FRESHMAN CONGRESSMAN, HAS IMMEDIATELY GONE TO WORK ON BEHALF OF THE VETERANS OF THE STATE OF FLORIDA. I MIGHT ADD THAT THIS GENTLEMAN HAS BEEN A COMMANDER OF A LEGION POST TWICE HERE IN THE DEPARTMENT OF FLORIDA, JUST WITHIN THE PAST SEVERAL YEARS.

WE SINCERELY APPRECIATE EVERYTHING THAT MIKE BILIRAKAS IS DOING ON BEHALF OF THE VETERANS AFFAIRS. HIS SEEKING OUT AN APPOINTMENT TO THIS COMMITTEE IS CERTAINLY AN INDICATION TO HIS DEDICATION TO THE VETERANS OF THE STATE OF FLORIDA.

AGAIN, WE THANK YOU FOR VISITING THE SUNSHINE STATE, AND WE WILL BE HAPPY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE REGARDING THE ITEMS THAT WE HAVE TESTIFIED TO HERE TODAY.

I THANK YOU VERY MUCH!

STATEMENT OF
CHARLES M. MCLEOD
LEGISLATIVE COMMITTEE MEMBER
DISABLED AMERICAN VETERANS
DEPARTMENT OF FLORIDA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
SEPTEMBER 8, 1983

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 52,000 plus members of the Disabled American Veterans in the State of Florida, may I say that we deeply appreciate the opportunity to participate in today's hearings, which deals with the subject of inpatient and outpatient medical services provided by the Veterans Administration to veterans residing in the VA's southeastern region with the principal emphasis being on those veterans who reside in the southern region of Florida.

In your letter of invitation to testify, Mr. Chairman, you requested that our testimony should "cover any aspect of the delivery of health care to eligible veterans you believe is pertinent to bring to the subcommittee's attention."

Mr. Chairman, Florida is a unique state in that while the overall number of veterans living in the United States has decreased in the past couple of years, the veteran population in the State of Florida has dramatically increased. Figures released by the Veterans Administration for the period ending March 31, 1982, reflected the total veteran population of this

26-829 O—83——8

country as being approximately thirty million living veterans (30,000,000). Florida's veteran population at that time was indicated as being one million three hundred and ninety one thousand (1,391,000). The Veterans Administration report released for the period ending September 30, 1982, approximately six months after the release date of the previous report, indicated that the total veteran population of this country had decreased to approximately twenty eight million five hundred and twenty two thousand (28,522,000), a net decrease of approximately 1.5 million veterans. At the same time, the figures reflected the fact that the veterans population of Florida had increased to one million four hundred and fifty nine thousand (1,459,000) or an overall increase of approximately sixty eight thousand veterans (68,000), during the six (6) month period.

From the above figures, it becomes very apparent that substantial numbers of veterans are, in fact, migrating to the State of Florida because of our excellent climatic conditions, reasonable cost of living and other factors which add to the "enjoyment of life".

Figures compiled by the Veterans Administration for fiscal year 1982, reflected the fact that the Veterans Administration had identified approximately 143,556 veterans who had service connected disability evaluations assigned by the Veterans Administration and who resided within the State of Florida. As you know, Mr. Chairman, individuals who have been rated service connected by the Veterans Administration are entitled to total medical care for their service connected disabilities, whether these disabilities are evaluated at 0% or 100%. In addition, Mr. Chairman, current law provides that if a veteran is rated 50% or more service connected for his disabilities, he, therefore, becomes eligible for inpatient and outpatient treatment for "any condition" without regard to whether it is service connected or not.

Mr. Chairman, from the veteran population figures which I have related to you, it becomes very apparent that the veterans who are migrating to the State of Florida are creating extra demands upon the VA's system of health care both in the inpatient and also in the outpatient categories.

Mr. Chairman, currently in the State of Florida, we have five Veterans Administration Medical Centers, these are:

Bay Pines VA Medical Center
Gainesville VA Medical Center
Lake City VA Medical Center
Miami VA Medical Center
Tampa VA Medical Center

In addition, Mr. Chairman, we do have a number of satellite Outpatient Clinics which are doing an excellent job of meeting the majority of the medical needs of our veterans.

Since approximately 50% of the veterans currently residing in the State of Florida had service in either World War I or World War II, it becomes very apparent that these individuals have now reached an age where their demand upon the medical services provided by the Veterans Administration will be increasing at an alarming rate. In addition to more frequent and prolonged treatment for their established service connected disabilities, these individuals will also be in need of treatment for numerous medical problems which will be brought on by their increasing age and development of other conditions. If the Veterans Administration's medical facilities in the State of Florida are to be in a position to continue to meet the needs of this ever increasing veteran population, it will be necessary for additional funding to be shifted into the medical district from areas of the country which are losing veteran population.

If the VA Health Care Delivery System in Florida is to be in a position to maintain both the quality and quantity of the care provided to the veterans here in Florida. Additional fundings will be necessary.

Mr. Chairman, the veterans who came to Florida to "enjoy the good life" now find themselves spending increasing amounts of time waiting to receive medical care at Veterans Administration Hospitals and Outpatient Clinics. They are finding substantial delays in being scheduled for appointments in certain clinics, and delays in obtaining admission to Veteran Administration Hospitals. In addition, once the veteran has been scheduled for an appointment in the clinic or in the hospital environment, he finds a great deal of delays between the time of his scheduled appointment and the time that he actually sees his examing and treating physician. Mr. Chairman, the only possible way to meet the needs of the ever increasing veteran population in Florida and to meet the new challenges being posed upon the VA Health Care Delivery System by an ever increasing population, demanding more frequent and more prolonged treatment, is by additional funding of the Health Care Delivery System.

Mr. Chairman, on behalf of the veterans in the State of Florida, we again thank you and the members of your subcommittee for travelling to Florida to hold these hearings on the quality of the health care provided by the Veterans Administration to Florida's veterans.

STATE OF FLORIDA
VETERANS OF FOREIGN WARS
OF THE UNITED STATES
543 N.E. SANCHEZ AVENUE
OCALA, FLORIDA 32670
904-622-5126

LESTER W. DAVIS, STATE COMMANDER
EDWIN SHUMAN, SENIOR VICE COMMANDER
CECIL BRANFORD, ADJUTANT-QUARTERMASTER
JAMES BURKHART, JR., VICE COMMANDER

STATEMENT OF KENNETH E. DONCASTER ON BEHALF OF THE VETERANS OF FOREIGN WARS, DEPARTMENT OF FLORIDA, TO THE SUB-COMMITTEE ON HOSPITALS AND HEALTH CARE OF THE VETERANS AFFAIRS COMMITTEE, U.S. HOUSE OF REPRESENTATIVES AT ORLANDO, FLORIDA ON 8 SEPTEMBER 1983.

Chairman Edgar and members of the Committee, my name is Kenneth E. Doncaster, Inverness, Florida, and I am pleased and honored to represent the Veterans of Foreign Wars, Department of Florida, as we once again consider the health care needs of Florida's veterans.

I have carefully studied the VA's Thirty Year Study of the Needs of Veterans in Florida issued in December 1982, as well as the Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida, published in June 1983.

These reports are a giant step in the right direction. As to new VA Hospitals, the VFW's main concern has to be the rate of implementation. I am sure this Committee would favor a "speed up" of the appropriations and construction process. The VFW feels that solutions to the medical problems of Florida's veterans have been long over-due. Accordingly, we feel that authorization and construction of new in-patient facilities should be on a "crash" or emergency basis, short-circuiting the normal bureaucratic procedures wherever possible. We fear that unless this is done, we will find the new facilities already inadequate to the need as soon as the doors are opened several years from now.

Meantime, continuing annual studies and up-dates should be conducted by the VA to insure the continued viability of proposed solutions, and to make appropriate mid-course corrections when needed. The Hospital bed problem in Florida has been "out of control" for years. Now, we have a plan. Let's implement it as fast as possible and maintain "control" of the program from now on!

The first time I testified before a Congressional body was in 1949 when I appeared before the Veterans Affairs Sub-Committee of the U.S. Senate Labor & Public Welfare Committee. This Sub-Committee was chaired by a young Florida Senator named Claude Pepper. Our objective was a new VA Hospital at Gainesville, Florida. Eighteen years later VAH, Gainesville opened its doors. What I am saying, Gentlemen, is - this time around, let's not take so damned long!

The VFW is equally concerned about the Out-Patient phase of the VA's Medical programs for veterans. With six satellite Out-Patient Clinics in being and two more planned at Pensacola and Daytona Beach, we are pleased that these studies recommend two more. A debate will arise as to precisely where they should be located. The VFW says - put'em where the bulk of the veterans are! This means to me that one of them should be in Western Pasco County in the Bayonet Point/Hudson area to provide more immediate access to the large numbers of veterans residing to the immediate north, in Hernando and Citrus Counties. These three Counties are where the veterans population growth has been - and will continue to be - explosive as the "Suncoast" moves northward by in-migration from the northern states and transplants from the larger cities to the south. Demographic studies support this view totally. Personally, I also believe that demographics support a new OPC in the Lakeland/Winter Haven area. I realize that

this would seem to be a large grouping of VA facilities in a relatively small area - but this is where the veterans are!

However, once we have taken care of the heavily populated areas in Florida, with new Hospitals at West Palm Beach, Brevard County and possibly Ft. Myers, and new OPCs at Pensacola, Daytona Beach, Pasco and Polk Counties, what do we do about the rest of the veterans residing in the large rural areas of Florida? The VFW's answer to this is to recommend a thorough study and analysis of the VA's Fee-Basis Out-Patient programs.

We think the House Veterans Affairs Committee should make this study on the grounds that the VA itself has been so close to the problem for so long that I would suspect a philosophical bias if such a study were done by the VA alone. I do not distrust the VA - I simply think that independent minds will produce a more realistic and un-biased solution. What is wrong with the Fee Basis Program?

Probably the greatest thing that ever happened to VA medicine occurred on January 3, 1946 when President Truman signed into Law the Omar Bradley Bill to create the Department of Medicine & Surgery. Since then the VA has helped train tens of thousands of physicians and surgeons, thereby improving the overall health care needs of all Americans. These same doctors are now needed as Fee-Basis physicians in the VA system to help those veterans they trained on!

But these doctors are not participating in the numbers required. Why not? This is what such a study should address. Many questions come to mind. Is the reticence of the private medical sector due to delays in payment for months on end? Is it due to seemingly unnecessary red tape and reports? Of the Doctors

that trained in the VA system, how many do participate? Of the doctors that did not train in the VA, how many participate in the Fee-Basis Program? In either case, what is their reasoning? Do they view VA Medicine as "socialized" and therefore anathema, causing a sense of embarrassment that they had to train there in order to become qualified? Are the Fee schedules inadequate? Does their own "union", the Florida Medical Society for example, encourage participation? When the VA and the professional Societies "negotiate" their annual Fee Schedules, is there any attempt by the VA to require a certain degree of participation without which the Contract would be void?

Perhaps many other questions will occur. But, basically, we feel that these Doctors should be queried directly by this Committee. Let's find out what the attitude really is. Once again we will find the facts pointing toward the solution. But the bottom line is that the private Medical sector is not working with the VA in sufficient numbers to insure availability of first-rate care to the veterans in the boon-docks who are in equal need and entitlement with their compatriots in the population corridors.

VA Medicine has moved more and more into the "team" concept of treatment as a viable modality in many areas. In the satellite OPCs, we now find the VA's Department of Veterans Benefits eliminating Veterans Benefits Counselors from the Clinic Staffs. DVB Staff in OPC Orlando was recently wiped out. We think this is a gross error in priority which is based not so much upon lack of need for the service as on necessary funding. This is a problem you, Gentlemen, can and should correct.

I appreciate the opportunity to testify before this Committee. I would be happy to attempt an answer to any questions the Members may have.

AMVETS
American Veterans of World War II Korea-Vietnam
144 1ST AVENUE-SOUTH, ROOM 470A
P.O. Box 1437 • St. Petersburg, Florida 33731

Daniel J. Cloutier, Sr.
NATIONAL SERVICE OFFICER

Telephone
CML (813)826-3718
FTS 826-3718

September 8, 1983

TO: HOUSE VETERANS AFFAIRS COMMITTEE

FROM: AMVETS

SUBJECT: HEALTH CARE FACILITIES

Mr. Chairman and members of the Committie: Thank you for the privilege of appearing before this distinguished committie to present the views of AMVETS, on Hospital/Health Care Services in the State of Florida.

The veteran population figures for the state of Florida indicates continued rapid growth as more and more retires especially WW II choose this warm climate to meet their needs. The average monthly increase in 1983 is estimated at nearly 5,000 which is a conservative figure.

The current medical facilities for veterans in Florida continues to be heavily used. We must not only look at todays needs, but tomorrows needs as well. It is essential that we take neccessary steps to provide the proper care for the ever increasing population of Florida Veterans.

We ask you to insure that the medical/health care programs are adequately funded.

Further, we support the development of out-patient clinics in areas that will service veterans who are located at great distances from current medical facilities.

We believe this concept will provide greater health maintenance and a corresponding savings in overall health care costs.

Also, we support a closely monitored allocation of medical funds and medical facility construction that is coupled with the demographic profile of veterans nationwide.

The movements of veterans to specific areas of this nation is ever increasing, and will continue into the near future, thereby creating an imbalance between previous allocated resorces and veterans needs.

There is another segment of the veteran population which deems as a big issue: the aging.

We ask for your continued oversight on the progress by the VA to provide adequate care to our aging veterans, both in health maintenance and the provision of nursing care facilities and domiciliaries.

Older veterans not only need long term care facilities and services, they require more acute care than their younger counterparts. Their care involves more physician time, they have more admissions in a given time period and they require longer stays for treatment of similar ailments.

We approach this era of the aging veteran with the view that it cannot and should not be met through any diminution in the integrity and comprehensivity of our health care system or in the quality of care we provide to all our veterans, aged or not.

The issue of the aging population and what means exist or must be acquired to deal with it creates a set of problems for not just the VA, not just for Federal systems, for society as a whole. The message about our challenges is clear, money is short; the times ahead will be tough; the need for managerial decisions will likely increase.

With this in mind, I beleive that we all have to do some fresh thinking about the whole matter. We must assure the aging veteran that the proper care needed will be provided.

Allocation of shrinking resources will become the health care art from of this decade, and we are convinced that the resource and workload challenges we face are not insurmountable.

We will, further, join our fellow Federal medical services in implementing sharing opportunities and in exploring new alternatives toward the accomplishment of our goal.

The VA strives to serve the American veteran and his family-with dignity and compassion; in fact, the VA is their principal advocate. Therefore, the VA must operate a good system and make sure our veterans receive all bebefits and the proper care to which they are entitled. "AMERICA is number 1 because of our veterans.

Proudly Serving Florida Veterans

Daniel J. Cloutier Sr.
AMVETS National Service Officer

SAM MOODY
AMERICAN EX-PRISONERS OF WAR

DRAFT

Good Afternoon, Mr. Chairman and members of the Sub-Committee,

On behalf of the more than 4,000 ex-Prisoners of War from the state of Florida, I would like to welcome you to Orlando and also to invite you to come back and visit with us again. We live in one of the most beautiful areas of the United States and are proud to welcome you here.

I deeply appreciate the opportunity to express the views of my fellow veterans on health care and the implementation of Public Law 97-37.

I will be speaking mainly on behalf of the most misunderstood veteran in America; "Namely the Former Prisoner of War." However, I do belong to the following Veterans' groups and hold office in most of them:

* Area Vice-President of the Air Force Association (over 10,000 Florida members and over 200,000 nationally).
* Adjutant of the Federation of Ex-Prisoners of War
* Special Chief of Staff of the DAV Dept. of Florida (1,000's of members)
* Past National Commander of the American Defenders of Bataan and Corregidor.
* Air Force Sgt's, The Purple Heart Society, Jojourners, Hero's of 76, other Veterans Groups(in the United States Air Force.)

I served my country for 21 years, 3 1/2 years of which was spent in a Japanese Prisoner of War Camp. I have lived in Florida for the past ten years and I'm very familiar with the Veterans of Florida, the Retired Military and their dependents and their Health Care problems.

My comments this afternoon will cover general points on medical support matters with special focus on the Central Florida Veterans' needs; namely, the area that is presently serviced by the Veterans' Administrations Orlando Clinic.

First, let me observe that the growing political trend to place medical

Support for the veteran, the military retiree and their dependents in a category of a non-commitment or a commitment of convenience is a gross violation of the fundamental contract under which military service was performed. The willingness of a citizenry to perform the military function (typically at considerable personal sacrifice) should be matched by a willingness of the government to perform in later years in accordance with the conditions perceived, if not stated, during the initial contract.

The non-active military segment has always agreed on two things:

1. Priority of medical service and support to the active force.

2. Acceptance of service to the non-active element on an "availability" basis.

The problem that arises in the medical support sphere is the same as that which is now arising with respect to retirement and that is the growing attempts to ignore or constrain the post service commitment and reward for sacrifice.

* QUOTE: President Theodore Roosevelt said:

> "A man who is good enough to shed his blood for his country is good enough to be given a square deal afterward. More than that no man is entitled to, and less than that no man shall."

As to the term "availability", that term was never understood to be synonomous with the idea of "non-availability." Non-availability is perceived as a temporary situation, not a built in shortage as it is today.

In an open letter to Congress, the Air Force Sergeant's Association recently made this point:

> The overriding considerations for not selecting the military as a profession must be counterbalanced with the maintenance and stability of institutional benefits, recreation, and a retirement system that will adequately compensate for the often adverse conditions in which individuals must serve, while in a highly disciplined and controlled environment during the better part of their lives and that of their families.

This view is endorsed in its entiristy. It applies not only to retirement but the entire system of post service support to include

the all important subject of this meeting — that being medical support.

Too often, we have seen full military service accepted with the delayed payment for that service argued after the fact,. This is not and should not be the pattern of actions of honorable men and an honorable nation.

During these two years the primary solution to this obvious need has been study and conversation and continues as such.

We cannot help but compare this lethargic and evasive action to the results of a survey of Retired Officers and enlisted personnel — which showed that 90% through age 70 were willing to report for military immediately on call. This is, of course, the response one would desire from a patriotic citizenry. We only think that the government should have the willingness to respond in a similar way.

The scale of responsiveness has been unbalanced too long — we ask that you correct it promptly.

In reflecting on this demand on our part, we refer you again to the Air Force Association Statement just quoted. There is bitterness that is developing over this issue of medical support in Florida, that is not only a disservice to the veteran, but is creating a negative environment with respect to our defense structure and the underlying manpower.

Involved are issues of commitment and honor. As far as we are concerned, neither the VA nor the elected representative have acted responsibly in this case.

In this regard recognize that about 9% of this nations retired military population resides in Florida.

To negatively influence such a large segment of the professional military family can only cause problems that no one would desire to have.

Today much time is being lost while various parties try to put a micrometer on Florida.

The seriousness of the situation, in our view, requires immediate and massive injection of remedial action. Should there be a slight over correction, it would be highly preferred to the massive under treatment that has

The Florida veteran, military retiree and their dependents' medical problem is big, it is growing rapidly and it is, in our view, significantly misunderstood and understated. Patr of this emerges from the business and political structure of the state of Florida whose focus is overwhelmingly on tourism and business acquisition. Military-related data within the state of Florida is only randomly acquired and seldom analyzed. Further, the attitude of much of the state is one of inhospitableness to the military connection even though the state is one of the highest beneficiaries of military related monies. In many U. S. localities, this meeting to establish medical support needs of the military would be championed by the business and political community who would edsire, as in the case of a prominent Texas city, to be a "friend to the military." In Florida, it is an unusual occasion when a business or political representative will step forward to positively support the military conversion. Here in Central Florida, it would be a rarity for one of the mayors to take a lead on Armed Forces Day or Veterans Day and the on-going trend is to ask the military associations themselves to pay the costs of any patriotic demonstration. In this environment, it is not unexpected that the needs of veterans might well be ignored.

How big is the Florida veteran problem?

The VA paper, A Thirty Year Study of the Needs of Veterans in Florida concludes that the veteran population is expected to grow by 12% by the year 1990. This growth of 12% over 10 years amounts to a compound annual growth rate of just over 1%. Unfortunately, the basis for this growth rate is not set forth in the study.

For comparison to the stated 1% annual growth rate, we note that the military retirees are growing in Florida at an annual

As noted, I am a member and officer of Air Force Association — an organization of some 200,000 patriotically-minded persons. At the last (1982) meeting of this organization it considered and updated its Annual Statement of Policy. This statement covers matters of defense to include issues of manpower. I think any person working with matters of defense and military manpower, to include veteran matters, should become familiar with this annual statement. For now, I want to read the Air Force Association's statement on "veterans" as it bears directly on the purpose of this meeting.

> We remain concerned about the public's inclination to forget, during peacetime, the sacrifices of both those who served during the past wars and those now serving on active duty. The problems encountered by Vietnam-era veterans, while moderating, remain a national concern. Broken promises to veterans, and neglect or disregard of their legitimate needs, are perceived by many active-duty people as major evidence of the public's low esteem for the military in general and are a factor in their assessment of the military as a career.

THE EX POW'S AND AFA SUPPORTS:

o Continued opposition to capping the cost of living increases for disabled veterans and federal retirees.

o The opposition to the continued shrinkage of the VA'S share of the federal budget.

o Continued medical treatment of veterans with nonservice-connected disabilities, and opposes postponement of construction and resources needed to treat the nonservice-connected disabled veteran.

o Greater government emphasis on training and jobs for Vietnam-era veterans.

o Extension of time restrictions on eligibility for earned veterans education benefits.

o Expansion of national cemeteries in numbers and size.

o Restoration of the $300 burial allowance to all veterans regardless of the cause of death.

o Changing the cutoff date of the old GI Bill from December to ten years after leaving active duty.

AM EX POW'S AND AFA OPPOSES:

o Any reduction to veteran's compensation, pension programs, and to the VA medical system.

o Reductions in compensation payments for service-connected disabled veterans.

o Reduction in VA medical care facilities, hospitals, clinics, domiciliary care or reimburseable travel funds for disabled veterans.

Looking directly at the Florida medical support problem as respects veterans, retirees and their dependents, one must observe that the gross deficiencies that we now see did not just happen. There has been a shameful neglect of the resident and transient Florida veteran, retiree and their dependents that has gone on for years. The Florida veteran population did not just arrive in Florida in 1983. We note that the VA paper, A Thirty Year Study of the Needs of Veterans in Florida, admits that, while on a national basis there are 3.0 beds per thousand veterans, in Florida there is only the equivalent of 2.0 beds per thousand veterans. We note with respect to these data that the 2.0 beds per thousand figure is a significant overstatement of capability in that it does not take account of the high veteran transient population in Florida. The Florida veteran (and other military) medical deficiency has existed for some time and it is of serious proportion. We regret that the VA has not seen fit to deal with this matter promptly and honorably and that the VA paper, A Thirty Year Study of the Needs of Veterans in Florida, the follow on paper, the Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida, and this meeting came about, not on the initiative of VA, but as a result of Public Law 97-101, enacted December 23, 1981. In this regard, we note that this is 1983 —that 2 years have elapsed during which time the problem of the Florida veteran has worsened and

been taking place and which is getting worse on a daily basis. With respect to this problem we note that military retirees are arriving in Florida at the approximate rate of 10 per day — and this figure has the potential of expanding considerably.

Mr. Chairman and members of the Committee, when I was first told about these hearings, I told everyone that I wanted it fully understood that I would not speak or say anything bad about the VA because I believe most sincerely that the VA is doing an outstanding job. Since then, in talking to the various veterans, and veteran's Associations, that I know in this area, all of them have said the same thing to me; "please say something good about our VA here in Orlando." Therefore, I would like to make it a matter of public record that the veterans of Central Florida feel that they are very lucky indeed to have Dr. Charles Silverblatt and his entire staff of doctors and nurses taking care of us.here at the Orlando VA Clinic. So far this year they have taken care of 68,000 veterans as of 1 Sept. With a work load like this Dr. Silverblatt should have been authorized a staff of at least 140 people, instead, he performs his mission with only 103 personnel. These people are sincere and dedicated. They treat us with kindness and respect. They have always made it a point to treat us the way veterans feel that they should be treated, with dignity, not as welfare cases. The results - the Veterans are grateful for their treatment.

You have asked us for suggestions or recommendations that might improve the health care for veterans in this area.

We have been hearing about a hospital for Veterans being built some place in the Central Florida area for some time. No matter where it is built, it will still take 5 or 6 years and yes, even longer, before any action is taken. In the mean time, Veterans are getting older, many will die long before any hospital action is taken. So, our suggestions are to take care of the Veterans that need help now and we can do that very simply by authorizing Dr. Silverblatt and the VA to have bed space available for Veterans in all of the local hospitals; at least five spaces in one or more of the local hospitals and yes, even some of the outlying areas, such as Brevard County and other nearby cities.

On a compound basis, this is a 10 year growth of over 25%. And there is every indication that this 2.3% growth rate (a 1980-1981 data point) understates the future, e.g. some select states already have military retiree growth rates well over 3.0%.

In that the reasons for veteran location or relocation to Florida will parallel the reasons for the military retiree's selection of Florida as a place of residence, we would have to assume that the VA projection of growth of 12% for the 10 year period ending 1990 could be off by as much as 100% or more.

Viewed in a different light, the Florida 1982-2000 population is expected to grow by 38.19%. A large portion of this population growth is via relocation. To suggest a growth in the veteran population significantly less than the general growth does not seem proper.

Another factor that creates uncertainty respecting the VA projection of veteran population for Florida is the seeming lack of an adjusting factor to take account of the transient veteran load -- the tourist and snowbird who is counted not in Florida but in another state.

Florida has a tourist influx that can be projected at approximately 40,000,000 persons annually. This equates to about an additional 1,000,000 plus full time residents.

Using the 1980 veteran to other population mix, Florida is, via the tourist and snowbird influx, impacted by about 125,000 additional veterans than the normal data reveals. This is, by itself, an increase of about 10% over the 1981 veteran population set forth by VA.

We would note, however, that this transient veteran population would not be uniformly spread across the state but would find a particular

focus in the Central Florida area of Disney World/Sea World/Orlando/Orange and Seminole Counties. Given that 50% of this transient veteran load is indeed concentrated in this Central Florida area, it has, by itself, the impact of doubling the veteran concentration in that area.

In summary, we find the VA assessment of Florida veteran population considerably on the low side. Potentially, the forecast 1990 veteran population as described by VA as 1,520,000 could be as much as 1,650,000. Further, today's services veteran population which is described by VA as about 1.4 million could, in consideration of the transient figure, be as much as 1.55 million.

* * * * * * * * *

As to the VA Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida, on behalf of myself and all those with whom I have consulted, I take certain exception:

1. Regrettable, the language and format of the study is significantly biased:

A. By using the name "Brevard" to describe a 9 to 11 county area, the inference is that Brevard County is the center of that area. This is not true.

B. By especially signalling out Brevard County as a "Proposed New VA Hospital Site," the VA has set forth an order of preference and made a pre-judgement of great impact.

C. By referring to all other hospital sites as "other counties in their group," the conclusion set forth above is reinforced.

D. By placing Brevard County in a priority position in listings and enclosures, the inference is that it is the first choice of VA and is more worthy of selection than are other locations.

The foregoing citations of evidence of bias have already led many persons to conclude that this meeting is no more than a formality prior to the selection of Brevard as the beddown of the VA hospital in this central area.

2. With respect to the Report's emphasis on Brevard, it is noted that the "Access Index" gives a greater plus factor to both Orange and Seminole counties as potential locations for a VA hospital. In that regard, the Report clearly states that a higher Access Index signals a preferred hospital location among the alternatives. The emphasis of Brevard County over the Orange and Seminole County locations when the latter counties have a positive index rating of 28% to 30% above that of Brevard is not understood or, from a veteran point of view, appreciated.

3. As to the county-by-county statistical methodology used by the VA in this Report, such would be somewhat valid if:

A. The population was equally distributed in each county.

B. The counties were of uniform size, configuration and relationship to one another.

In that neither of the foregoing is true, the Report can only produce a significantly slanted and untrustworthy output. One would have to note that the county-by-county analysis fails to take account of the very obvious centers of population. A case in point is the population center stretching through Orange and Seminole counties. For all practical purposes, these two counties could be viewed as one for the purpose of this veteran analysis — this is actually how most of the residents view this area. In many ways, Seminole County, rather than

being adjacent to Orange County, is surrounded by Orange County. But, even if this obvious concentration of population cannot be statistically viewed for what it is, it is apparent that, using the existing VA methodology, the placement of a VA hospital in the midst of this population center (at the Orange/Seminole County border) would develop a statistical zero travel distance for about 50% of the served veteran population. This type of statistical logic would produce even higher "Access Index" figures for an Orange/Seminole hospital site over, as example, a Brevard County site.

4. While the "Access Index" has certain utility in providing a general focus for a VA hospital site, it is recommended that the final decision on siting be judged on a "User Convenience and Cost Basis." Such a figure can be arrived at by mulitplying the persons served by the distance to the serving facility — this calculation produces answers quite different that does the "Access Index." By example, developing a "User Convenience and Cost Basis" for the three primary contesting locations of Seminole, Orange and Brevard Counties, data are as follows:

Seminole County Site	15,254,760 miles
Orange County Site	17,558,200 miles
Brevard County Site	24,420,240 miles

In other words, a Seminole or Orange County VA hospital site is from 40% to 60% better than a Brevard County site. Placing real dollars on this equation, which equation assumes one trip per person per year to the VA hospital site, annually, compares to a Seminole County site, 9,165,480 unnecessary miles would be driven to use a Brevard site. At thirty miles per hour, this would ensume 305,516 extra driving man hours per driver and over 600,000 man hours per vehicle considering a two occupancy situation — driver and patient. In an atmosphere of energy and man hour conservation,

a waste such as this should not be built into any program.

5. Perhaps more important than the potential for built in waste as described above is the time penalty that could be involved in a Brevard County alternative. Weighing total served population against total service miles driven as in the paragraph above, the average round trip service miles per each location are as follows:

Seminole County Site	53.14 miles
Orange County Site	61.06 miles
Brevard County Site	88.10 miles

While these differences are significant of themselves, look at what these data mean in time lost — time which could spell the difference between life and death. At an average speed of 30 MPH, the enroute time to a VA hospital site would be:

Seminole County Site	.88 hours
Orange County Site	1.02 hours
Brevard County Site	1.46 hours

If, as suggested above, the VA hospital would be sited on the Orange/Seminole border, the data are even more favorable:

Orange/Seminole Sites	13,197,960 or 16,623,880
Brevard County Site	24,420,240

On average, a Brevard location has about 50% the attraction of an Orange/Seminole location and twice the service costs involved for the veteran population. If the transient veteran population, as set out below, is considered, this difference is magnified considerably.

6. While the foregoing provided overwhelming data in support of an Orange/Seminole site for a new VA hospital, the situation is even more pronounced when the tourist/snowbird population is brought into focus. With the center of the tourist interest being

in the Disney World/Sea World/Orange/Seminole area, the bulk of that transient veteran impact must be accomodated in that proximity. As stated, on an annual basis, this transient veteran load equates to a full time veteran population of about ~~250~~ 125,000. This is about ~~equal~~ 50% to the projected veteran loadings set forth in the VA Report for the VA-identified "Brevard" region — that being either 277,190 or 287,050 veterans. If one introduces this very real transient statistic into the calculation, there is not only an over-riding value that emerges to support a VA hospital site in the Orange/Seminole area but there also arises data to support ~~almost a doubling~~ A SIGNICANT INCREASE of the size of that facility!

7. On a more minor note, we would note that while the VA Report calculates against a basis that the Seminole veteran is serviced from Tampa, the fact is that the Seminole veteran is serviced from Gainesville. We did not check the Report for other such inaccuracies.

* * * * * * * * * * * *

Commenting generally on the criteria related to a VA hospital location, it is our recommendation that all future VA hospitals be co-located with a major university regardless whether such university presently has a medical teaching college. A VA hospital is a very permanent implant and it should be located in light of future probabilities.

* * * * * * * * * * * *

Returning to the VA paper A Thirty Year Study of the Needs of Veterans in Florida, I do have some pertenient comment:

1. Data has an inaccuracy emerging from the fact that a lack of veteran medical service has forced individuals to employ private

means. We believe this fact (which is not measurable) is evident in the note that 55% of the Florida outpatients were service connected beneficiaries as compared with 44% nationally while in the case of Florida hospital discharges 36% of the patients were service connected as compared to 30% on a national basis.

2. As to the emphasis on psychiatric care, while there is undoubtedly much data to support the growth of this need, many of us hold strong suspicions that the need is more encouraged than real.

* * * * * * * * * * * *

In closing, and reflecting the views of myself and others, I think it is a disgrace that we are standing talking about something that should have been resolved and acted upon years ago. If the military conducted a battle in the fashion of this subject, we would lose all wars. In the medical parlance, while this operation is being performed, the patient is dying.

Instead of standing here talking, we should be pouring concrete and raising steel. But, based on what I see, I doubt that we will see action on this urgent problem in the near future, or if at all. In the meantime, we will have thousands of veterans who will not be serviced as they have every right to expect to be.

I urge the committee to avoid making this matter either a pork barrel issue or a partisan issue. Veterans are Americans and they deserve an American response taken in their interest. To do less would be to fly in the face of prior veteran service, the continuing commitment of veterans, of veteran statistics, of logic and of those very human considerations of which we all should be possessed.

Presented by

Major General John O. Moench, USAF-Retired
905 Sweetwater Blvd. South
Longwood, Florida 32779

At the request of and on behalf of
the veterans of Central Florida
and in the interests of our Nation.

There comes a time for counting and for accounting and it appears that that time is now at hand.

I am Major General John Moench, Air Force Retired, a resident of Longwood, Florida and a business person of Orlando, Florida. After thirty-two (32) years of military service on behalf of our Nation, service which included not only some sixteen (16) years in our Nation's capital but which took me to every continent and most wars since the forties, I retired in 1974 to assume a vice presidency of a major New York corporation. Later I reestablished myself and family in Central Florida.

Since coming to Central Florida, I have been associated with a cross section of the veteran population in military related organizations, socially and via business. Concerned about the deteriorating military situation in Florida and the short and long term effects on the state, along with other military analysts, we have completed a study of the military presence and influence in Florida, its characteristics, impacts, synergisms and more.

It was this analysis that led me to assist in the preparation of certain testimony for various veteran persons scheduled to testify before this subcommittee. Subsequently, John Piner, AMVET District #2 Commander, Don Arthur of the Military Order of the Purple Heart and other veterans asked me to consolidate and present the combined thoughts of this Central Florida veteran community to this subcommittee.

This request was indeed an honor but it also was an enormous responsibility in that it placed me in the position of attempting to speak fairly for well over 100,000 Central Florida veterans. Further, because I abhor bias, it also meant that I had to consider the interests of veterans of adjacent areas, of the state of Florida and more.

In bringing these consolidated thoughts to you, we have tried to communicate with all the veteran related groups in the Central Florida area and for the record at Tab A to this presentation you will find a listing of such groups.

I cannot say that, in the time available, we achieved 100% communication in this case, but every communication that was concluded did support the key elements of thought that I will present to you.

I will also add that the Central Florida Chapter of the Air Force Association, an organization which annually hosts all the mayors in Central Florida, communicated with each of those mayors on the matter of veteran medical needs and, to this moment, there has been nothing but positive support of the various thoughts presented to those mayors, which thoughts parallel that which I shall cover. For the record, at Tab B, is a listing of the mayors of Central Florida.

The matter we are looking at today, the health care of veterans, is

not a subject that should be viewed in isolation. Discussions and actions on this matter relate to a fulfillment of contract, serve as a guideline for and influence respecting future service decisions of individuals and impact heavily on the social and economic framework of the community. Those who have made the military service their commitment understand this more than do others and I would, at this time, like to quote to you from a recent open letter to Congress from the Air Force Sergeant's Association:

> The overriding considerations for not selecting the military as a profession must be counterbalanced with the maintenance and stability of institutional benefits, recreation, and a retirement system that will adequately compensate for the often adverse conditions in which individuals must serve, while in a highly disciplined and controlled environment during the better part of their lives and that of their families.

As a senior military officer, I can only endorse these views, When you make a decision respecting the treatment (or non-treatment) of veterans, you create influence that descends right down to and through the enlistment and retention process.

Among the military related organizations represented in Central Florida is the Air Force Association -- an association of some 200,000 patriotically-minded persons -- an association that is proud to have many members of the Legislative Branch among its members -- one of whom is Congressman McCollum.

This Association, over half of whom are war veterans, after a careful analysis of the military and related needs of the United States, annually issues a comprehensive policy statement covering defense issues. One of the elements of that policy statement bears directly on the veteran issue we are now discussing. I want to read an extract of the pertinent points impacting this meeting.

> We remain concerned about the public's inclination to forget, during peacetime, the sacrifices of both those who served during the past wars and those now serving on active duty. The problems encountered by Vietnam-era veterans, while moderating, remain a national concern. Broken promises to veterans, and neglect or disregard of their legitimate needs, are perceived by many active duty people as major evidence of the public's low esteem for the military in general and are a factor in their assessment of the military as a career.
>
> The Association supports:
>
> - o Continued opposition to capping the cost of living increases for disabled veterans and federal retirees.
>
> - o The opposition to the continued shrinkage of the VA's share of the federal budget.

o Continued medical treatment of veterans with nonservice connected disabilities, and opposes postponement of construction and resources needed to treat the nonservice-connected disabled veteran.

o Greater government emphasis on training and jobs for Vietnam-era veterans.

o Extension of time restrictions on eligibility for earned veterans education benefits.

o Expansion of national cemeteries in numbers and size.

o Restoration of the $300 burial allowance to all veterans regardless of the cause of death.

o Changing the cutoff date of the old GI Bill ... to ten years after leaving active duty.

The Association opposes:

o Any reduction to veteran's compensation, pension programs, and to the VA medical system.

o Reductions in compensation payments for service-connected disabled veterans.

o Reduction in VA medical care facilities, hospitals, clinics, domiciliary care or reimburseable travel funds for disabled veterans.

These policy statements have been discussed among members of the Central Florida veteran community and they have been endorsed as reflecting the essentials of their views. They would add and emphasize, however, that a de facto reduction of veterans' benefits is occurring daily in Florida as a result of the continuing growth of the veteran population without commensurate growth in the veteran facilities.

What is the problem that we are trying to measure? How did this problem come about? What solutions are needed now and later?

While I do not like to criticize, the veteran situation we are now examining in Florida seems to have roots in an inattention to the dynamic demographics of the State. No system is perfect and, with respect to veterans, there have been a lot of mistakes. Fortunately:

1. Veterans are enormously patient and forgiving.

2. In most cases, such as respects the American prisoners of the Philippines, the Nation eventually corrects a wrong.

As to the veteran problem in Florida, it cannot be minimized. It is big and it is growing. Further, it has all the characteristics

of growing even faster for its solution can actually increase the scope of the problem.

The Florida veteran problem is an anomaly -- it is not something common to the whole of the United States -- it is the equivalent of a "federal impact area."

The Florida veteran problem also is not something of today -- a surprise. It is something that has been building for some time but, through neglect, it has not been recognized in a timely way and, unrecognized, it has not been treated progressively. This is not an arguable point.

Today, as a result of progressive deterioration in the match between need and capability, there is a considerable canyon that must be bridged -- and this canyon must be bridged fast. I would not like to see this problem solved after the patient has died.

VA Medical District 12, which includes 59 counties of the state of Florida and 19 counties of southern Georgia had a measured increase in veteran population from 1970 to 1980 of 43.3% while the Nation as a whole had only a 3.8% increase in veteran population.

According to the 1980 census, the veteran population in Florida had, by then, climbed to 1,352,253 or 13.8% of the total state population of 9,746,324 -- 17.7% of the civilian persons 16 years and over (7,627,052).

As to where the veteran population will go in the decade through 1990, one has to wonder about the reliability of a VA forecasting system that seemed surprised by the 1970 to 1980 growth having an ability to project a 1980 to 2000 growth. We would note in this regard that the VA veteran population projections for 1990 have been repeatedly judged to be in error with now the Medical District Initiated Program Planning (MEDIPP) projecting a 15% increase in veteran population in Florida in the 1980-1990 decade. However, in contrast, we note that the paper, "A Thirty Year Study of the Needs of Veterans in Florida" projects a 12% growth in the decade ending 1990. This is about a 1% annual growth rate. Compared to this figure, we know that military retirees in the state of Florida are currently growing at a rate of 2.3% per year -- over twice the projected growth of the veteran population. In that the same motivations that cause the military retirees to come to Florida also cause the broader veteran population to locate to Florida, it is suggested that the VA 12% growth projection may fall considerably short of the real situation.

We also note that the VA planning to which we have been exposed fails to take into account the transient population of the state of Florida -- a transient population that is increasingly impacting on the Central Florida tri-county area of Orange, Seminole and Osceola.

Currently, the state of Florida (Department of Commerce) considers

that the transient population (tourists) in Florida is the equivalent of 1,000,000 full time residents. Assuming that this figure is somewhat correct, that is the equivalent of placing an additional veteran load on Florida of about 130,000 -- an increase of some 10% over the stated veteran population loads. In that this transient veteran load would be highly concentrated in the Central Florida tri-county area, the impact on the facilities in this community could be as much as 20% or more.

Historically, there have been objections heard respecting the Florida veteran situation that to provide veteran facilities in the state, particularly facilities such as a state home, would increase rather than decrease the problem in that the provision of such facilities in this attractive area of the United States would bring more to the state and, thereby, increase the scope of the problem. If there is validity in this conclusion, and we believe there is some, then the provision of veteran medical services in Florida up to the level of the standards in the rest of the United States will accelerate the movement of veterans to Florida.

Examining other data, we do note that the military retiree's preference of retirement location is impacted significantly by the availability of service facilities. One of the key questions considered by retiring military persons is the availability of medical support -- particularly if the individual has any sort of medical problem. If improved veteran medical support is provided in Florida, it can be expected that the flow of veterans to the state will increase beyond current projections. While this is not a measurable fact, it is still a fact. In this regard, there is strong evidence to indicate that the current 2.3% growth of military retirees in the state would be considerably larger if the medical support facilities in the state were enhanced.

In summary, we have a deep concern that the veteran population figures now being employed to project future veteran needs in Florida are significantly understated and, with that, the future problem is understated. Regardless, the disparity between the number of veterans now here and the availability of veteran resources suggests a more than adequate basis for prompt action.

In discussing veteran needs, one cannot proceed without some attention being directed to the fundamentals of that need. This is not a charity nor a welfare program as some crude persons would imply.

Veterans are the surviving persons of the military forces of the Nation. The condition of these survivors varies from whole to badly damaged. All of them, in some way, gave up things to commit their persons and family to the defense of the Nation and the pursuit of its political objectives. Many, by the time they left service, no longer had available the options that were possessed by the non-serving community.

When, as a senior officer, I acted to project military forces and persons into traumatic environments, I knew that some would not

come back and others would not come back whole.

Now, when I, as others, acted to carry out the political purposes of the Nation as established by the Legislative and Executive Branches of Government, we acted with the confidence that, for those who survived, there would be compensatory action taken by the governmental bodies that ordered the event in the first place.

Today, however, there seems to be a growing political and public trend to place medical support for these veterans, the military retiree and their dependents in a category of non-commitment or a commitment of convenience. As far as we are concerned, this is a gross violation of the fundamental contract under which the military service was performed. The willingness of a citizenry to carry out the military function should be matched by a willingness of the government to perform in later years in accordance with the conditions perceived, if not stated, during the initial contract.

With respect to this contract, the military segment has always agreed on two things.

1. A priority of medical service and support to the active duty forces.

2. The acceptance of service to the non-active duty element on an "availability" basis.

The problem that arises in the sphere of medical support is that the term "availability" is becoming synonomous with the term "planned non-availability." "Non-availability" was perceived as a temporary situation -- not a permanent situation.

What we have in Florida with respect to medical care is a built in non-availability. The non-availability starts in the medical facilities of the active forces. These facilities, often hard pressed to meet the needs of the active duty forces, are simply not staffed nor funded to meet the degree of external requirements that exist in this community -- and the deficiency is growing -- not diminishing. The result is that medical requirements that in other parts of the United States might be satisfied by the active establishment are increasingly thrown to the outside where they then impact on the already inadequate veteran facilities or become something that in desperation is handled personally rather than in accordance with the contract between the serviceman and the Nation.

I did not realize how critical the medical situation was in Florida until I returned to the state in 1977. Almost immediately, I was confronted with conversation in the Central Florida military community that the local medical support was so constrained that "if you aren't bleeding heavily, don't ask for help."

I laughed at these statements as exaggerations. Then, one day in late 1977, my wife was struck with a severe back problem --severe

enough that I called for an ambulance to take her to the hospital at the Naval Training Center. What happened next was beyond anything that I could have believed had I not experienced it myself.

After some three hours in the emergency treatment room and with my wife immobile on a treatment table, I was told to call an ambulance and take her back home in that, while they had hospital beds open, they didn't have a staff to take care of her nor the funds to transfer her to a civilian hospital. That afternoon she did enter a civilian hospital and stayed there for the next ten days.

This extreme event was followed shortly by my son becoming seriously ill. Repeated treatment by medical corpsmen (never a doctor) solved nothing and the problem, improperly diagnosed and improperly treated, increased steadily. Finally, with conditions reaching the emergency state, my wife insisted that he be taken to a civilian hospital where the attending person, this time a real doctor, immediately diagnosed the problem. Hospitalization brought my son around but, had there not been prompt action to engage outside medical help, the situation could have had serious consequences.

After these two events, I vowed that I would call on the military medical service structure only as a last resort. Fortunately, my income and insurance program allow me a choice in such matters -- other veterans may not be so fortunate.

Incidentally, you may not have noticed it but the increasing use of non-doctors for the diagnosis and treatment of military patients and their dependents has now developed an embryonic movement among service wives, the National Coalition of Enlisted Wives.

On balance, I must say that, locally, the Orlando VA Clinic under the direction and supervision of Dr. Charles Silverblatt is doing a noble job. I am advised that, as of September 1 of this year, this clinic has taken care of 68,000 veterans. This, I understand, is more of a workload than his limited staff would be expected to handle. That the staff handles such a large workload cheerfully and courteously is a credit to the dedication of Dr. Silverblatt and his people. Health is important and Dr. Silverblatt recognizes this -- and his patients appreciate it.

Incidentally, looking at the Clinic's March 1983 patient load, one would have to note that about 70% of that load is from the counties of Orange and Seminole -- only about 10% from Brevard County. This is an indication of where the veteran population and workload resides in this area.

There are two important aspects to personal security: financial and medical or health. While the former can serve to insure the latter, the latter can destroy the former.

Throughout service life, the idea of later financial and medical security is quite dominating. We now face the prospect that for hundreds of thousands of Floridians that security has been remarkably

diminished and is, day-by-day, diminishing further.

When I first talked to Mr. Richard Fuller about this meeting today and my testimony, we discussed the emotions attending this matter and he asked me not to further arouse the emotions already present. As I explained to Mr. Fuller, this is an emotional matter -- it is emotional because we are dealing with the health, life and fortunes of the individuals. It is made even more emotional because this meeting was generally interpreted by the majority of the veterans as a positive step toward an early solution of the problem. As they came to understand that this meeting was only a session to hear commentary and that a real solution to the Florida veteran problem was most likely some five (5) or more years off -- and may not be realized at all -- emotions could only rise.

The electricity attending this matter has been further raised as a result of the conclusion that the attempt through MEDIPP to remove politics from the veteran equation seemingly has succeeded only in replacing it with what appears to be a secondary set of politics.

While Mr. Fuller suggested that the site selection for a Central Florida VA hospital was not intended as the focus of this meeting and that the issue of location was open, I had to advise him that circumstances had overtaken that view. For the veteran public, those thousands of veterans, the over-riding issue and the perceived purpose of this meeting is the site selection, or a narrowing of site selection, for a Central Florida VA hospital. Of interest, word received by some veterans is that site selection is already fixed in VA channels and this meeting is only window dressing. The focus of recent VA study, the focus of news articles and the focus of discussion and communications has been new VA hospitals in Florida to meet the pressing VA need. Frankly, I don't relish the role of carrying the news to the veteran population that these hospitals may well be a thing of the distant future -- if at all.

As to VA hospital location alternatives in Central Florida, the so-called "fat in the fire" really started with the issuance of the "Final Report on Future Bed Needs and Potential Sites for New VA Hospitals in Florida." I understand that the primary author of this report is Mr. Malcolm Randall and the report has now picked up the short title of "The Randall Report." For brevity, I will use this short title.

Congressman Nelson was kind enough to provide copies of the Randall Report to Central Florida veterans several weeks ago. This report, which in language seemed to strongly favor a Brevard County location over other Central Florida possibilities -- without, however, actually saying so -- caused quite a stir among veterans and others who on reading it found that the supporting statistics led to a different conclusion.

Whether the author of The Randall Report intended to have that

report actually constitute a direct recommendation of Brevard as the site of a VA hospital in Central Florida remained unclear until an alleged rebuttle of an article written by Sandra Mathers of The Orlando Sentinel surfaced. This rebuttle, allegedly written by Mr. Randall to address the Sandra Mathers article, "Veterans plan battle over hospital site," was quite clear in its support of the Brevard VA hospital site. This rebuttle paper is attached to this presentation as Tab C. In response to the points allegedly made by Mr. Randall in this rebuttal paper, I enclose to this presentation the comments of Don Arthur, Past National Commander of the Military Order of the Purple Heart (Tab D). His analysis is superbly adequate and needs no elaboration by me -- in sum, the Randall rebuttal in support of the Brevard siting is without weight.

Looking directly at the Randall Report as provided to us by Congressman Nelson, we had to sense an element of bias. These elements are set forth in Tab E of this presentation.

The Randall Report relies heavily on an "Access Index" to measure the value of alternative VA hospital sites. This index is a measure of "statistical miles" saved as compared between the new location and the old serving VA hospital sites -- the higher the "Access Index" the more preferred is the alternative location. In the Central Florida area, The Randall Report states these "Access Index" ratings for the three alternative VA hospital locations of Brevard, Orange and Seminole Counties as:

Brevard	12,446 (poorest choice)
Orange	16,175
Seminole	15,886

With the Brevard rating about almost 30% worse than the other ratings, its selection was unclear and seemingly contrary to facts.

Statistical analysis of the type used in The Randall Report is weak at best for it presumes an equal population distribution and county configurations of uniform scope and relationship. Neither is, of course, true. By example, Seminole County although adjacent to Orange County is seemingly surrounded by Orange County. Also, the Brevard population has a noticeable north/south coastal configuration.

While we viewed the "Access Index" used in the Randall Report as having certain usefulness in providing a general focus for a VA hospital site, we found a "User Convenience and Cost Basis" to be much more realistic in establishing priorities. Such a figure is easily developed using the same data as The Randall Report but establishing not the value of the statistical saving but the amount of the resultant statistical cost in miles and time.

Using the "User Convenience and Cost" basis of evaluation, we established relative values as follows (see Tables 1, 2 and 3):

Seminole	18,134,760
Orange	19,104,440
Brevard	24,420,240 (poorest choice)

In this analysis, the larger number was the poorer choice. These numbers reflect the total miles to be travelled assuming each veteran makes one round trip to the serving VA hospital site per year.

Looked at another way, using a 30 mile per hour average road speed, the elapsed time (one way) to get a patient to the alternative hospital sites would on average be:

Seminole	1 hour 5 minutes
Orange	1 hour 7 minutes
Brevard	1 hour 28 minutes (poorest choice)

The almost 50% penalty attending the Brevard site alternative does not appear acceptable, especially since a maximum safe enroute factor in emergencies is often stated as 1 hour.

It should be emphasized that the foregoing data were developed using the exact figures employed in The Randall Report. The negative Brevard date point would be much emphasized if the transient veteran population were brought into the equation.

An option that we believe should be looked at is a Seminole/Orange border location of the VA hospital. Statistically, this would give the Seminole and Orange County populations a zero travel distance. This option is developed in Table 4 of this presentation -- it reduces the statistical enroute time to under one hour.

But, in the final analysis, no siting of a VA hospital, if one is authorized for Central Florida, should be done on a pure statistical basis. That would ignore, we believe, the real world and real world considerations of fact.

For real world consideration we recommend the following as key criteria in any Central Florida VA hospital siting:

1. Nursing homes should be co-located with serving hospitals.

2. VA hospitals should be co-located with significant universities. (In this regard, while the presence of a medical teaching college at such university is a plus, the VA facilities are of such intended duration that their existence will most likely encourage such facility should it be absent.)

3. In Florida, VA hospitals or nursing homes should not be located proximate the coastal areas where hurricanes could require inland evacuation.

These criteria do, without much study, lead one to suggest that any VA hospital and nursing home in Central Florida be co-located with the University of Central Florida. Because of this and because there has been conversation that the University would not desire such co-location, we asked the University for their views and they are attached as Tab F to this presentation -- these views support such co-location. We would note that such a location is one already favorably examined by Congressman Nelson -- this according to the cited article in The Orlando Sentinel.

Of interest, the University of Central Florida suggested site for a VA hospital has the statistical impact of virtually reducing service distance to zero for the three counties of Brevard, Orange and Seminole. Further, the road network to such a location is very good.

Having said all the foregoing, it must be noted that none of it solves the immediate and pressing veteran problem. This growing problem -- growing in numbers and growing because of the advancing age of the veteran problem -- has to be dealt with immediately. This is not a problem that can be realistically swept under the calendar of time.

According to our latest statistics, we have right now about 10 military retirees being added to the Florida population every day -- how many additional veterans are being added each day we do not know. Regardless, we do know that each day the scope of the Florida problem is increasing in severity. In these special circumstances special action is needed. Desireably, new hospital and nursing home capacity should be brought into service as a matter of utmost priority. But, even with that sort of effort, there is still a need to reinforce the present situation. To do that, we recommend that the existing active duty military medical facilities be brought to maximum use through augmentation of personnel and budget. This will take a load off the overloaded veteran facilities. We also ask that the existing veteran facilities, such as the Orlando VA Clinic, be reinforced with personnel, funds and contract bed space in area hospitals. With respect to the latter point, we do not reject the idea that a significant portion of the veteran medical need be handled on a contract basis with civilian hospitals and that VA facility projections be reduced accordingly.

We also believe that the matter of veterans' needs in Florida, which subject has had a Washington to local dialogue and pipeline, should be entered actively by the Governor of Florida.

While the commitment to veterans is national, there are special factors in the case of Florida.

As already noted, the veteran population in Florida comprises about 20% of the Florida voting age population making it, we believe, the largest identifiable minority in the state. And, in the circumstances already described, we know that the Florida veteran, as measured against the service level in the U.S. as a whole, is discriminated against. Further, the evidence suggests that this discrimination is increasing -- not decreasing.

We also know that the treatment of the Florida veteran problem is already having a negative impact on the economics of the state, its ability to acquire business and investment, and its lustre as a place of retirement. If the Florida state government is not yet appropriately aware of this impact, it should be.

Today, the state of Florida is one of the highest beneficiaries of military monies and benefits.

In the single case of military retired pay (which income is only a fraction of the whole of military income to the state), the state of Florida receives almost 10% of the total U.S. pie -- on a per capita basis this is about 10 times that received by the state of New York. Annually, the Florida "take" of military retired pay is, at last count, over $1.2 billion and growing. In that this is net receipts to the state economy, in relation to typical sales of goods and services, that is the equivalent of well over $20.0 billion annually.

Florida's government expends massive monies protecting endangered wildlife and wetlands. We think it is time that Florida earmarked some of the monies it realizes from the military connection to protect that endangered relationship -- a relationship that is vital to the future of the state.

As first steps in this proposed scenario, we call on the Governor of Florida:

1. To work with the VA (and the Congress) to fix the Florida locations and land requirements for all potential VA hospital, nursing home and other veteran related facilities and, with state funds, to acquire immediately such lands for dedication to the VA. While such action has merit on its own, it also will serve to quiet the on-going VA medical facility location controversy, to avoid the loss in the future of the most desireable options, and to allow VA and public concentration on the prime issues -- that being the facilities themselves.

2. To act immediately with the VA (and the Congress) to establish a series of jointly funded, hospital supported veteran nursing homes in Florida adequate to meet the forecast demand for such facilities.

In June 1983, Florida Trend magazine outlined the massive benefits Florida received and still receives from the military connection --

in some counties it is the backbone of the economy having contributed up to 26% of the income. Quoting from Florida Trend, "In the very early days . . . the military was clearly a knight in shining armor rescuing desperately poor sections of Florida."

Today, largely due to the military connection, Florida has become rich. Now Florida has a chance (and obligation) to repay its debt. Concern for veterans ought to be higher than the concern for alligators.

In closing, and reflecting the views of myself and others, I think it is a shame that we are still talking about something that should have been acted upon years ago. If the military conducted a battle in the fashion of this subject, we would lose all wars. In the medical parlance, while this operation is being performed, the patient is dying.

In overview, this is not a political problem and it should not be a pork barrel undertaking. Veterans are Americans and they deserve an American response taken in their interest. To do less would be to fly in the face of prior veteran service, the continuing commitment of veterans, of veteran statistics, of logic and of those very human considerations of which we all should be possessed.

I thank the subcommittee for its time and, for all of those who contributed to this presentation, we offer our continued support for the solution so sorely needed and which only you can initiate.

VETERAN ORGANIZATIONS OF CENTRAL FLORIDA

Air Force Association, Central Florida Chapter

Air Force Sergeants Association

American Legion Post #19

American Legion Auxiliary #19

American Legion Post #53

American Legion Auxiliary #53

American Legion Post #227

American Legion Auxiliary #227

American Legion Post #238

American Legion Auxiliary #238

American Legion Post #242

American Legion Post #286

American Legion Auxiliary #286

American Legion Post #330

American Legion Department Headquarters

American Ex-Prisoners of War, Central Florida Chapter

American Federation of Ex-POW'S, D.A.V., Chapter 124

American Veterans Post #17

AMVET'S Post #30

AMVET'S District #2 Commander

Bahia Temple Legion of Honor

Daedalians

Defenders of Bataan & Corregidor

Disabled American Veterans #16

Disabled American Veterans Auxiliary #16

Disabled American Veterans #104

Disabled American Veterans Auxiliary #104

Fleet Reserve Association 117, Navy World Branch

Jewish War Veterans Post #759

Jewish War Veterans Auxiliary #759

La Societe Le Femmes

Marine Corps League, Orlando Detachment

Military Order of the Purple Heart

Military Order of the World Wars, Central Florida Chapter

Orange City Vietnam Veterans Memorial Committee

Paralyzed Veterans of America

Pearl Harbor Survivors Association

Reserve Officers Association, Chapter #12

Retired Officers Association, Central Florida Chapter

State Honor Guard, VFW Post #3405

Veterans of Foreign Wars, Post #4305, District #18

VFW #10050, Casselberry Post #4305

VFW Auxiliary #4305

VFW Orange County Post #2093

VFW Auxiliary #2093

VFW Winter Park-Maitland Post #10180

VFW Post #8152, Pine Hills

VFW Post #10139, Oviedo

VFW Post #10139 Auxiliary

VFW Post #5405, Winter Springs

VFW Post #5405 Auxiliary

VFW Post #10108, Sanford

VFW Post #10108 Auxiliary

VFW Post #4305, West Orange

VFW Post #4304 Auxiliary

VFW Post #4287, Goldenrod

VFW Post #4287, A.E.M.

VFW Post #8207, Longwood

VFW Post #8207 Auxiliary

VFW Post #4305, West Orange Auxiliary

VFW District #19, Post #1590

VFW Post #2380 Auxiliary Dickinson-Thompson, Deland

John E. Mealy Memorial Post, VFW Auxiliary #2382

Women Marines Association, Central Florida Chapter

VFW Post #4304

Veterans and Patriotic Council, Orlando

Voiture #202 40/8

Voiture #478 40/8

World War I Barracks #237, Orlando

World War I Barracks #3144, Altamonte Springs

Third Marine Division Association

Gold Star Wives

CENTRAL FLORIDA MAYORS

Apopka:
John Land - City Hall, P.O. Dwr 1229, Apopka, Fl 32703
Phone: 889-2594

Altamonte Springs:
Raymond Ambrose Jr -225 Newburyport Av, Altamonte Spgs, Fl 32701
Phone: 830-3801

Belle Isle:
Frank Borgon - P.O. Box 13135, Orlando, Fl 32859
Phone: 843-3600

Casselberry:
Charles H. Glascock - 95 Lake Triplet Dr, Casselberry, Fl 32707
Phone: 331-0553

Eatonville:
Abraham Gordon - P.O. Box 2163, Eatonville, Fl 32751
Phone: 644-3521/647-0061

Edgewood:
Dorris Bobber - 357 Harbour Island Rd, Orlando, Fl 32809
Phone: 851-2920

Kissimmee:
George Cant ---- 9 Glendale Dr, Kissimmee, Fl 32741
Phone: 933-2121

Lake Bunea Vista:
Alain Boniec - P.O. Box 40, Lake Buena Vista, Fl 32830
Phone: 828-2034/824-6823

Lake Mary:
Walter Sorenson - City Hall, P.O. Box 725, Lake Mary, Fl 32746
Phone: 323-7910

Longwood:
Ms June Lormann - City Hall, 175 W Warren Av, Longwood, Fl 32750
Phone: 831-0555

Maitland:
James Houser - P.O. Box 66, Maitland, Fl 32751
Phone: 644-8895

Ocoee:
Cliff Freeman - P.O. Box 456, Ocoee, Fl 32761
Phone: 656-7866

Orlando:
Bill Frederick - City Hall, 400 S Orange Av, Orlando, Fl 32801
Phone: 840-2222

Oviedo:
Robert Whittier - P.O. Box 159, Oviedo, Fl 32765
Phone: 365-3286/365-5333

Sandford:
Lee Moore - P.O. Box 1697, Sandford, Fl 32771
Phone: 322-2424

St Cloud:
John Crawford - 339 Illinois Av, St Cloud, Fl 32769
Phone: 802-5166

Windermere:
Carl Patterson - 219 Third Av, Box 556, Windermere, Fl 32786
Phone: 876-2080

Winter Garden:
Ralph Fulford - P.O. Box 1005, Winter Garden, Fl 32787
Phone: 656-4111

Winter Park:
Hope Strong - 916 Palmer Av, Winter Park, Fl 32789
Phone: 644-9860

Winter Springs:
John V. Torcaso - City Hall, 400 N Edgemon Av, Winter Springs,
Fl 32708: Phone: 327-1800

FACTORS RELEVANT TO SITE SELECTION FOR NEW VA HOSPITALS IN FLORIDA

I. PROCESS

The District Planning Board (representing all existing Florida VA facilities and comprising a majority of clinicians objectively adopted principles, standards, and criteria for site selection prior to the consideration of any sites, as follows:

A. Principles:

-New construction of hospital beds should be in an area which would improve accessibility to inpatient care for the greatest number of veterans.

-New hospitals should be located at sites which would minimize the negative impact on the utilization of existing (or other planned) hospitals.

B. Criteria for Selecting Potential Sites:

-Only those counties with a minimum veteran population of 10,000 which are also part of a metropolitan statistical area (MSA) should be considered.

-Only those counties that are at least 50 miles from an existing VA medical center should be considered, except for counties with a high density veteran population bordering on a potential site.

C. Standards for Determining Feasible Sites:

-Inpatient hospital services should be available within 50-75 miles of 80-90% of the District veteran population.

-The PSA of a new hospital with primary and secondary services should include those counties which are closer to the proposed facility site than to existing VA hospitals.

-The PSA of a new hospital should have a projected minimum veteran population of 150,000 by 1995.

-New hospitals should be located at sites which would minimize the negative impact on the utilization of existing (or other planned) hospitals.

Additionally, the Board pre-determined indicators of access discrepancy for assessing areas of unmet need for potential sites as follows:

-Number and rate of VAB applications by county.
-Number and rate of fee basis visits by county;
-VA discharge rates by county and service area; and
-Beds per veteran population in the northern, central, and southern service areas.

These principles, standards, criteria and indicators were reviewed and endorsed by facility planning committees and the Veterans Review Group. Copies were also shared with the Florida Congressional Delegation for their information.

Only 13 Florida counties met the adopted criteria for consideration as potential sites. Data relavant to principles, standards and access indicators were then collected and applied to theoretical PSAs which were developed for each potential site in order to determine feasible sites.

II. SELECTION OF FEASIBLE SITES

Four geographic areas of the state were identified as feasible sites based on the Board's analysis. Within each area, more than one county was considered feasible, but selection of one county would automatically rule out the selection of another in the same geographic area. Palm Beach County was selected over Broward County; Lee County was selected over Sarasota County; Brevard County was selected over Orange, Seminole and Volusia Counties; and selection of one of three feasible sites in the Panhandle (Bay, Escambia or Okaloosa) was referred to the Medical District 10 Planning Board. Based on Board analysis, the selected sites were placed in priority order: Palm Beach, Brevard, Panhandle and Lee.

Important points to be made regarding site selection are:

—An objective, representative process was used.
—Principles, standards, criteria and indicators were determined prior to consideration of any potential site.
—Data were collected and applied to total theoretical PSAs (developed on pre-adopted criteria) rather than to individual counties.
—Data were applied equally to each of the 13 potential sites in the context of total state needs.
—Eleven counties were considered to be feasible sites, but selection of one in each of four geographic areas ruled out others in the same area.

III. JUSTIFICATION FOR SELECTING ORANGE COUNTY OVER BREVARD

Questions have been raised regarding the selection of Brevard County over Orange County as the favored feasible site. The Board carefully applied all of the information relevant to adopted principles, standards and criteria to each county in the geographic area to determine where access would be best improved with the least impact on existing VA medical centers. Some of the most significant factors considered by the Board in this decision are:

—Brevard County is farther away from any existing VA hospital than Orange County is.

—Utilization of existing VA hospitals indicates that Brevard has less access to these facilities; thus a larger number of veterans may be served who are not now using VA services due to poor access.

--The theoretical PSA for Brevard would bring more veterans within 75 miles of a VA facility (who are currently more than 75 miles from an existing VA hospital) than would the theoretical PSA for Orange; thus better access would be provided throughout the area.

--Location of VA hospital in the proposed PSA would have less impact on the workload of existing facilities than location in the proposed Orange County PSA. The closer a new hospital is placed to an existing hospital, the more patients will be drawn away from the existing hospital. This could result in poor utilization of already invested resources. However, in either case, tertiary care would continue to be provided in Tampa or Gainesville.

--A VA presence exists in Orange County in the form of an outpatient clinic and the approved Medical District Plan provides for construction of a 120-bed Nursing Home Care Unit there. There is no VA presence in Brevard County. The Orlando OPC provides entry into the VA system as a satellite facility of the VAMC Tampa.

PROPOSED TESTIMONY

Donald J. Arthur
Past National Commander
Military Order of the Purple Heart

The following opinions are hereby stated with reference to site selection of a new VA hospital facility in central Florida. These positions are taken after careful study of the VACO report to this committee in June.

First, I wish to emphasize that this is not an altercation between two political entities over a political and economical plum but hopefully a frank and open discussion about bringing service to the greatest number of veterans.

We propose to keep the hospital site in the so called Brevard Primary Service Area and recommend that it be located approximately 35 to 40 miles west of the proposed site in Cocoa, Florida.

This is based on the following:

1) Veteran Population

A review of Maps 4, 5, and 6, and Tables 4, 5, and 6, Appendix I, of the VACO report indicates that 66.4 percent of the total estimated veterans' population (or 184,060) will reside in Orange, Osceola, Seminole and Volusia Counties. The remaining 33.6 percent, or 93,160 veterans, will reside in the other six counties of the Brevard PSA. The total veteran population for the PSA being estimated at 277,000 by 1995.

Mileage to the proposed site from the more heavily populated counties is greater than if the site were to be located in eastern Orange County.

The figures below are VACO straight line distances from Tables 4 and 5, Appendix I:

County	Distance From Brevard Site	Distance From Orange Site
Orange	46	0
Osceola	41	20
Seminole	47	14
Volusia	62	44

From the above it would appear that the greater number of veterans residing in the Brevard PSA would have to travel the greater distances to reach the proposed hospital.

2) Road Accessibility

The VACO report totally ignores both the existing road net and the proposed one that will be constructed in the rapidly developing eastern Orange County area. There are

more roads connecting directly from the counties of Volusia, Seminole and Osceola into the eastern area of Orange County. The roads for the same counties to the proposed site in Cocoa are somewhat less by comparison.

The VACO report also brings out the concept of negative impact or the locating of a new facility too close to an existing facility or to another new facility. The negative impact being the drawing off of veterans from the old to the new.

It is our experience and also our understanding that for the most part veterans are assigned to a specific hospital for treatment and do not wander indiscriminately to a hospital of their choice.

To further refute the concept of negative impact on the VA system in Florida, now and as projected, the Thirty Year Study of the needs of veterans in Florida states that the veterans' population in the state will increase by 12 percent, or 177,937, to a total of 1,703,480 by the year 1990. This will be happening at a time when the nation's veterans' population will have declined by 5 percent. Assuming this projection to be valid, it is difficult to foresee any negative impact on VA facilities now or in the foreseeable future.

As our discussion contemplates relocating the proposed hospital site within the Brevard Primary Service Area, it must be pointed out that there are certain circumstances that apply here which differ from other populated areas of our state. All other heavily populated areas of Florida are located along the shore line. In central Florida, the populated area is not on the shore line; indeed, it is 50 or more miles inland.

It appears that the VACO, in accepting the statistical data submitted, has moved through the center of the population in its rush to the coast.

In recent statements to his veterans' review group, the Director of Medical District 12 stated, "A VA presence exists in Orange County in the form of an outpatient clinic and the approved medical district plan provides for construction of a 120 bed nursing home care unit there. There is no VA presence in Brevard County. The Orlando OPC provides entry into the VA system as a satellite facility of the VAMC Tampa."

In refuting this statement, I wish to advise you that it is, and has been, my understanding that VA outpatient clinics were not to be a factor in considering hospital site selections.

Also, it would appear that the continued presence of the Orlando clinic could not be guaranteed. In the recent past, the VA has closed its outpatient clinic in downtown St. Petersburg and relocated it in the newly constructed Bay Pines Hospital some miles distance.

To further the cause for siting the hospital closer to Orlando, we might ask the Director of Medical District 12 why the outpatient clinic was located in Orlando in the first place.

I feel reasonably certain that essentially the criteria applied to this decision would now apply to locating the hospital in the same general area.

The projected nursing home of 120 beds, while needed and necessary, is already inadequate. It has been my privilege for the past two years to travel extensively to inspect VA facilities and I have visited several nursing homes of the current design. All were in close proximity to VACMs; indeed, as often as not on the same grounds. VA Medical District 12 has not made public why it chose Orange County for the nursing home. The question is "why did they?" Any veteran being relocated from the proposed hospital site in Brevard County (Cocoa) to the nursing home would have to travel 50 miles to get to Orlando for such care.

Mr. Edgar, I wish to thank you for this opportunity to appear before you and your committee.

THE RANDALL REPORT

Preliminary Indication of Potential Bias

Toward a Brevard PSA

- By using the name "Brevard" to describe a 9 to 11 county area, the inference is that Brevard County is the center of that area. This is not true.
- By especially signalling out Brevard County as a "Proposed New VA Hospital Site," the Report has set forth an order of preference and made a pre-judgement of great impact.
- By referring to all other hospital sites as "other counties in their group," the conclusion set forth above is reinforced.
- By placing Brevard County in a priority position in listings and enclosures, the inference is that it is the first choice of the Report and, in some way, is more worthy of selection that are the other locations.
- By stating that the "feasible sites for new hospitals" were Palm Beach County, Brevard County, Florida Panhandle and Lee County, the implication was present that other sites were not feasible; yet, nothing in the Report suggeststhat that is a fact. While the Report states that Section V would include sites "feasible with shortcomings," either that category was not developed or it was excluded from the copy of the Report made available to the veterans.

COMMUNICATION FROM

THE UNIVERSITY OF CENTRAL FLORIDA

TO BE ADDED

TABLE 1

SEMINOLE COUNTY PSA -- USER CONVENIENCE AND COST BASIS*

(Data from The Randall Report Table 6)

A PSA County	B Distance From Site	C Veteran Population (1995)	D Mileage (B X C)
Seminole	0	38,930	0
Brevard	47	48,320	2,271,040
Flagler	52	2,000	104,000
Indian River	91	11,290	1,027,390
Lake	28	17,780	497,840
Okeechobee	103	3,160	325,480
Orange	12	85,700	1,028,400
Osceola	31	9,770	302,870
St. Lucie	106	16,350	1,733,100
Sumter	46	4,090	188,140
Volusia	32	49,660	1,589,120
TOTAL		287,050	9,067,380
ROUND TRIP MILEAGE (D X 2)			18,134,760
TRIP AVERAGE PER PATIENT			63.18 Miles
SERVICE TIME TO HOSPITAL @ 30MPH AVERAGE			1 Hour 3 Minutes

*Assumes one visit to hospital per veteran per year.

The Randall Rebuttal (Tab C) states that 80-90% of a PSA veteran population should be within 50-75 miles of the serving VA hospital. In the Seminole PSA set forth above, 89% of the veteran population is within 50 miles of the serving VA hospital. This compares to only 70% of the veteran population in a Brevard PSA falling within the 50 mile criteria.

TABLE 2

ORANGE COUNTY PSA -- USER CONVENIENCE AND COST BASIS*

(Data from The Randall Report Table 5)

A PSA County	B Distance From Site	C Veteran Population (1995)	D Mileage (B X C)
Orange	0	85,700	0
Brevard	62	48,320	2,995,840
Flagler	64	2,000	128,000
Indian River	86	11,290	970,940
Lake	28	17,780	497,840
Okeechobee	94	3,160	297,040
Osceola	20	9,770	195,400
St. Lucie	100	16,350	1,635,000
Seminole	12	38,930	467,160
Sumter	44	4,090	179,960
Volusia	44	49,660	2,185,040
TOTAL		287,050	9,552,220
ROUND TRIP MILEAGE (D X 2)			19,104,440
TRIP AVERAGE PER PATIENT			66.55 Miles
SERVICE TIME TO HOSPITAL @ 30MPH AVERAGE			1 Hour 7 Minutes

*Assumes one visit to hospital per veteran per year.

TABLE 3

BREVARD COUNTY PSA -- USER CONVENIENCE AND COST BASIS*

(Data from The Randall Report Table 4)

A PSA County	B Distance From Site	C Veteran Population (1995)	D Mileage (B X C)
Brevard	0	48,320	0
Indian River	47	11,290	530,630
Martin	84	14,010	1,176,840
Okeechobee	70	3,160	221,200
Orange	46	85,700	3,942,200
Osceola	41	9,770	400,570
St. Lucie	63	16,350	1,030,050
Seminole	47	38,930	1,829,710
Volusia	62	49,660	3,078,920
TOTAL		277,190	12,210,120
ROUND TRIP MILEAGE (D X 2)			24,420,240
TRIP AVERAGE PER PATIENT			88.10 Miles
SERVICE TIME TO HOSPITAL @ 30MPH AVERAGE			1 Hour 28 Minutes

*Assumes one visit to hospital per veteran per year.

The Randall Rebuttal (Tab C) states that 80-90% of a PSA veteran population should be within 50-75 miles of the serving VA hospital. In the Brevard PSA set forth above, only 70% of the veteran population is within 50 miles of the serving hospital. This compares to 89% of the veteran population in a Seminole PSA falling within the 50 mile criteria.

26-829 O—83——12

TABLE 4

ORANGE/SEMINOLE COUNTY PSA -- USER CONVENIENCE AND COST BASIS*

(Data from The Randall Report Tables 5 & 6)

A PSA County	B** Tables 5 & 6 Distance	C Distance From Site	D Veteran Population (1995)	E Mileage (C X D)
Orange		0	85,700	0
Seminole		0	38,930	0
Brevard	62/47	54.5	48,320	2,633,440
Flagler	64/52	58.0	2,000	116,000
Indian River	86/91	88.5	11,290	999,165
Lake	28/28	28.0	17,780	497,840
Okeechobee	94/103	98.5	3,160	311,260
Osceola	20/31	25.5	9,770	249,135
St. Lucie	100/106	103.0	16,350	1,684,05C
Sumter	44/46	45.0	4,090	184,050
Volusia	44/32	38.0	49,660	1,887,080
TOTAL			287,050	8,562,020
ROUND TRIP MILEAGE (E X 2)				17,124,040
TRIP AVERAGE PER PATIENT				59.66 Miles
SERVICE TIME TO HOSPITAL @ 30MPH AVERAGE				59 Minutes

*Assumes one visit to hospital per veteran per year.

**Distances to site taken from Tables 5 & 6 and averaged in column C.

UNIVERSITY OF CENTRAL FLORIDA

BUSINESS AFFAIRS OFFICE OF THE VICE PRESIDENT

ORLANDO, FLORIDA 32816 (305) 275-2555

September 6, 1983

Major General John Monench, USAF Retired
905 Sweetwater Boulevard S
Longwood, FL 32779

Dear General Monench:

The purpose of this letter is to provide to you information regarding the location of a new Veteran's Administration hospital and nursing home somewhere in East Central Florida.

I have discussed the matter with the appropriate people at the University and I can advise you as follows. As with you and many others, the University is desirous of seeing the hospital located somewhere in the area. Each proposed site has advantages and disadvantages and at present the University has no strong feelings about where it might be located. The College of Health at the University offers programs which may be mutually advantageous to the hospital and to the University.

It is our understanding that there may be a number of obstacles to either location dealing with traffic, sewage and water and I am sure those will be carefully weighed by the site selection committee. The University will be interested in cooperating with the hospital regardless of the site that is finally selected.

I hope the above information will assist the group as they arrive at their decision. If I may provide additional information, please advise.

Sincerely,

John P. Goree

John Philip Goree
Vice President for Business Affairs

CITY OF APOPKA FLORIDA

September 6, 1983

Subcommittee of the
U. S. House of Representatives
Committee on Veterans' Affairs
Aviation Authority Board Room
2nd Floor, Main Terminal
Orlando International Airport
Orlando, Florida

Gentlemen:

Due to the fact Florida has a growing veterans' population, and currently provides only two (2) beds per 1,000, I urge you to consider the following during your subcommittee meeting here in Orlando on September 8:

1. That a veterans' hospital be placed in the Orange/ Seminole area, preferably co-located with the University of Central Florida; and

2. That contract services be provided and adequately funded until the completion of the VA hospital.

Your serious consideration of this request will be greatly appreciated.

Sincerely yours,

John H. Land
Mayor

JHL/sbm

cc: John P. Piner, Amvets
Louis C. Kriebel, Air Force Association

Mayor: JOHN H. LAND Councilmen: ALONZO WILLIAMS, JR. J. WILLIAM ARROWSMITH RICHARD L. MARK DETMER L. ROUZER
P.O. DRAWER 1229, APOPKA, FLORIDA 32703 PHONE (305) 889-2504

SEP 19 198

CITY OF
PALM BAY
FLORIDA

175 NW PALM BAY RD. • 32905

OFFICE OF THE MAYOR

September 7, 1983

The Honorable Bob Edgar
Subcommittee Chairman
House Veterans Affairs Subcommittee
on Hospitals and Health Care

Dear Representative Edgar:

I am writing to you regarding support for the Veterans Administration Hospital in East Central Florida, pursuant to the V. A. Final Report on Bed Need and Potential Sites for new V. A. Hospitals.

In addition to being mayor of a 65 square mile city located in Brevard County, I am a service connected disabled veteran. I can only cite the phenomenal growth being experienced in this City as an example of what is happening here. Palm Bay continues to lead all other municipalities in Brevard County and Central Florida in population growth. In absolute numerical growth, Palm Bay ranked ninth in the State from 1980-1982 and fourth in rate of growth among cities which have had the greatest increase in population over that period. This extremely rapid growth is exceeding all projections. I point this out merely as an example of what we are experiencing throughout this area.

As a past Chapter Commander in the Disabled American Veterans, I am aware that our members drove veterans over 43,000 miles to V. A. medical facilities during my tenure as commander. I am pleased that Brevard County is seriously being considered as the focal point for the nine Central Florida counties. When we look at the primary V. A. service areas of Tampa and Gainesville hospitals, the geographic location of Brevard County is very logical. I certainly have no complaints with the medical care that I have received from the Orlando V. A. Outpatient Clinic or the V. A. Hospital in Tampa. I do strongly urge favorable consideration and approval of a Central Florida V. A. Hospital. In addition, that the hospital be located in Brevard County to provide the best V. A. primary service area coverage.

Sincerely,

CITY OF PALM BAY

Bill Madden

William F. Madden
Mayor

WFM/ld

"CITY WITH A FUTURE"
AN EQUAL OPPORTUNITY EMPLOYER

October 28, 1983

Honorable Bill Nelson
House of Representatives
Washington, D. C. 20515

Dear Bill:

Thank you for forwarding to me the comments of Mr. Wilson McGee, concerning spinal cord injury units in Florida's VA Medical Centers.

Mr. McGee's comments will be made a part of our Subcommittee's September 8th hearing record.

Sincerely,

BOB EDGAR
Chairman, Subcommittee on
Hospitals and Health Care

bpd

Congress
of the
United States
House of Representatives

BILL NELSON
FLORIDA
ELEVENTH DISTRICT

COMMITTEES:
BUDGET
SCIENCE AND TECHNOLOGY

October 6, 1983

The Honorable Bob Edgar
Chairman
Subcommittee on Hospital and
Health Care, Veterans Committee
2352 Rayburn House Office Building
Washington, D.C. 20515

Dear Bob:

Pursuant to your Subcommittee's formal hearing in Orlando, Florida, I am forwarding the comments for Mr. Wilson McGee for your consideration.

Mr. McGee has personal experience with the VA medical facility at Tampa, Florida, where his son is presently under care in the spinal cord unit.

I appreciate your review of this statement and its inclusion in the hearing record.

Thank you for your kind attention.

Sincerely,

Bill

BN:sls
Enclosure
cc: Mr. Wilson McGee

IN RESPONSE, PLEASE REPLY TO:

WASHINGTON OFFICE
307 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515
(202) 225-3671

MELBOURNE OFFICE
68 EAST NASA BOULEVARD, SUITE 202
MELBOURNE, FLORIDA 32901
(305) 724-1578

ORLANDO OFFICE
FEDERAL BUILDING, SUITE 300
ORLANDO, FLORIDA 32801
(305) 841-1778

KISSIMMEE OFFICE (305) 847-0753
MERRITT ISLAND OFFICE (305) 459-1778
TITUSVILLE OFFICE (305) 268-1778
VERO BEACH OFFICE (305) 569-1578

WILSON McGEE MANAGEMENT, INC.
WILSON CHANDLER, McGEE, PRESIDENT

P. O. BOX 3611
ORLANDO, FL. 32802
[redacted]
(305) 425-9062

Sept. 26, 1983

Subcommittee Chairman Bob Edgar,(D.PA)
House Veterans Affairs on Hospitals and Health Care
% MC Bill Nelson, 11th District of Florida
307 Cannon House Office Building
Washington, D.C, 20515

Re: Regional Hearing Sept.8,
Orlando, FL.

Dear Congressman Edgar:

For reasons set forth in my letter to Congressman Bill Nelson, I was unable to attend your subcommittee meeting in Orlando. I so advised Congressman Nelson and he agreed to forward any statement of mine for your subcommittee's consideration.

My name is Wilson McGee,1791 Aloma Avenue, Winter Park,Fl. I am a non-veteran but my son George Wilson McGee is an honorably discharged disabled veteran who served in the Korean conflict with the U.S. Navy after his initial three-year enlistment term was extended by Act of Congress to four years.

George is presently in the compassionate care of the Spinal Cord unit of the VA Hospital, Tampa, where his mohher and I try to visit him weekly. We are getting old and our son, through a civilian accident for which his employer denies liability, is a guadaplegic on life support system while undergoing a superlative rehabilitation effort by the Spinal Cord staff. When George was injured Feb.8 of this year at Ft. Lauderdale, his civilian doctor said he would live only four days at most when his spinal cord was smashed at the C-2,C-3 level. Without reflection upon the care he received there, Mrs. McGee and I were convinced he needed to be removed to a VA hospital and Tampa was the closest one to us with a spinal cord unit. In my opinion, they saved his life or at least gave him a chance for one.

This is why I write, from personal knowledge that may also help someone else's son.

The East Central Hospital as proposed, whether in Melbourne, Cocoa or Orlando, is fine for the future. It is needed but the site location should be left to the Veterans Administration and

The Congress. My concern now is what can be done in the interim by your subcommittee to alleviate existing conditions as to hospital health care with existing facilities.

As I understand it, there are only two VA Florida hospitals with spinal cord units, Miami with 36 beds; Tampa with 42. Spinal cord treatment is increasing not only from service but the stress of civilian life for veterans. I cannot say what is the Miami status but from my own personal observation the Tampa unit needs additional beds desperately. I have walked the corridors to filled rooms. I have seen the recreation rooms and the therapy rooms all filled. I am certain that if your committee should be inclined to inquire the need for additional hospital beds for this unit alone at Tampa is overwhelming. I can only guess this for when my son was transported to the VA hospital, he had to be immediately placed in respiratory intensive care before he could be moved back to the Spinal Cord Unit. And the respiratory unit was filled.

The purpose of this is to call to your attention that while 200 additional beds have been authorized (and I would hope funded) for Tampa, the construction of this additional facility which should include additional spinal cord accomodations is now scheduled for 1987.

I would hope that on the basis of need that this schedule be moved up to 1986 at the very latest.

While new hospitals are in the needed future, Congressman Edgar I believe the needed expansion of the Tampa installation is vital. There you have a compact installation with University of South Florida Hospital and Teaching College which now helps the VA tend not only Central Florida veterans but those from the burgeoning Tampa Bay area.

Even should an East Central Florida institution be eventually built in my view the Tampa Bay metropolitan growth justifies expediting the Tampa VA construction not only for spinal cord but all hospital and nursing home facilities. The year 1987 is a long way from the present need. Please shorten the Tampa expansion time. Doris and I will continue to drive there weekly.

WCM/wc

Sincerely yours

Wilson C, McGee

CC: Bill Nelson, M.C.
11th District, Florida

SEP 19 198

September 3, 1983

The Honorable Bob Edgar
Chairman
House Veterans Affair Subcommittee
Hospitals and Health Care

Dear Mr. Edgar:

It is my understanding your committee is currently in the process of conducting regional hearings on the need for additional Veteran medical facilities in Central Florida.

As you are aware the present disposition of VA facilities is such that they are not readily supportive of the majority of veterans residing in Florida. This situation exists for a variety of reasons: but, hopefully will be corrected by future medical facility construction at a site which will better accommodate the large number of veterans located on the East Central coast of Florida. At present there is more than adequate capability to meet the medical needs of veterans on the West coast and the recently renovated excellent clinic in Orlando fulfills a high percentage of the requirements for veterans residing in the central portion of the state. Further, on the West coast and in the Orlando area there are active military installations that provide a full range of services to veterans. In the Brevard area there are no VA facilities and the medical facility at Patrick is under staffed and lacks skilled medical personnel for other than the most routine problems. This situation has worsened in the past five years and all indications are that there will be even a lesser capability for treatment and longer lead time for medical appointments in the future.

The ever increasing veteran population along the east central coast of Florida makes it essential a VA medical care facility be established in Brevard County. This county has an excellent road net and sufficient skilled medical personnel to provide contract expertise to a VA facility.

Your determination to cite a VA medical facility in Brevard will ensure proper distribution of facilities and be in the best interest of the persons VA facilities are chartered to accommodate.

Sincerely,

Arnold S. Stallman

561 Capri Road
Cocoa Beach, FL 32931

CITY OF OVIEDO

"Friendly Community"

Seminole County, FL
32765

VIA: HAND DELIVERY

Subcommittee
U.S. House of Representatives
Committee on Veterans' Affairs
Aviation Authority Board Room
2nd Floor
Main Terminal
Orlando International Airport
Orlando, Florida

Dear Sirs:

I sincerely hope that your committee today will forget political considerations and locate the Veterans' Administration (VA) Hospital in Orange County or Seminole County adjacent to the University of Central Florida, which has an established school of nursing.

This is mandated because Orange and Seminole Counties will be more impacted by rapid growth by the year 2000 than any other part of Florida.

Very truly yours,

CITY OF OVIEDO

ROBERT W. WHITTIER
Mayor

RWW/pbs

cc: Air Force Association, Louis C. Kriebel
Senator Paula Hawkins
American Veterans of World War II, John P. Piner
Dr. Coburn, President, University of Central Florida

Enclosures

(305) 365-3445 Public Works
(305) 365-3287 City Hall
(305) 365-5101 Police Dept.

Growth puts Florida on track to No. 3 . . .

UNITED PRESS INTERNATIONAL

WASHINGTON — Florida will squeeze New York out of the big three states in population by the year 2000, while Vermont will slip below Alaska to become the smallest state, the government predicted Wednesday.

California, now the largest state, will retain that distinction at the turn of the century, with Texas moving up to the No. 2 spot, the Census Bureau said.

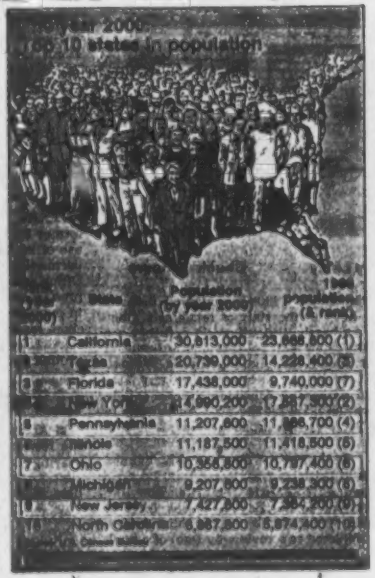
The West as a whole will continue as the fastest-growing region and Nevada, keeping up its dramatic population boom, will approach 2 million people at the turn of the century, the bureau said.

The new report, offering projections by state for 1990 and 2000, is based on trends established from 1970 to 1980 and adjusted for expected changes in birth and death rates.

It suggests that the shift of political power that came with transfers of congressional seats from the aging Northeast and North Central industrial regions to the Sun Belt of the South and West will accelerate.

The Commerce Department agency estimated that the nation's population as a whole will reach 267,461,000 by the turn of the century, an increase

Please see **GROWTH, A-13**



	State	Population by year 2000	1980 population (& rank)
1	California	30,813,000	23,668,500 (1)
2	Texas	20,739,000	14,228,400 (2)
3	Florida	17,438,000	9,740,000 (7)
4	New York	17,990,200	17,557,900 (3)
5	Pennsylvania	11,207,800	11,866,700 (4)
6	Illinois	11,187,500	11,418,500 (5)
7	Ohio	10,358,800	10,797,400 (6)
8	Michigan	9,207,800	9,238,300 (8)
9	New Jersey	7,427,800	7,364,200 (9)
10	North Carolina	6,987,800	5,874,400 (10)

Census Bureau

. . . with staggering building job ahead

By Harry Straight

OF THE SENTINEL STAFF

Florida will have to build the equivalent of a new Miami every year for the next 16 years if it hopes to accommodate the steamroller growth that is expected to catapult it from the seventh-largest state to No. 3 by the year 2000.

The 17.4 million population estimate released Wednesday by the Census Bureau is far above the 14.6 million predicted by Florida economists for the turn of the century.

"It's very high," said Dr. Henry Fishkind, director of the Bureau of Economic and Business Research at the University of Florida and head of its forecasting program. He said the projection may be too high because it is based on growth during the 1970s.

High interest rates that dent home buying and selling and a dwindling pool of potential migrants from other states indicate that the growth spurt of the last decade may not be repeated, Fishkind said.

Using the state's most conservative estimates, Florida is expected to make room for almost 300,000 new residents each year. Add another 80,000 if the Census Bureau's projection proves true, equaling the current population of Miami.

In either case, the state will continue to be host to

Please see **BUILDING, A-13**

BUILDING

From A-1

nearly 40 million visitors every year, perhaps more.

Newcomers will continue to be drawn primarily to the cool breezes and glittering sands of the coastal communities, where more than 86 percent of the state's population eventually will settle, state economists predict.

The Orlando and Ocala areas will be exceptions to the coastal trend. Central and Southwest Florida will be the hottest growth areas while the Northwest region will be slowest.

Seminole County is expected to grow to 345,200 residents — an increase of 92.6 percent — and will continue to be the second-fastest in growth among counties with more than 100,000 population. Pasco County on the west coast is and will continue to be the leader.

Florida at the dawn of the 21st century will be far different from the place described by John James Audubon in 1832 as "a garden, where all that is not land, mud, mud, is sand, sand, sand, where the fruit is so sour that it is not eatable, and where in place of singing birds and golden fishes, you have . . . alligators, snakes and scorpions."

The garden likely will be replaced with concrete, condos and crowds, according to some doomsayers.

"Our badly designed highways are going to become ever more crowded and dangerous. Water supply will become more critical and more precarious — and much more expensive. State, county and municipal services will make desperate efforts to catch up but will fall even further behind. But it is always going to look just perfect to the new arrivals, because it is so much more pleasant than what they left behind," wrote author John D. MacDonald in the June issue of *Florida Trend*. His novels have focused on the impact of growth on the state.

If the Census Bureau report proves accurate, the numbers alone are staggering.

More than 7,400 new people will arrive in Florida each week, creating a demand for 3,200 homes and 38 miles of new roadways. Each newcomer will require 100 gallons of water a day from the state's wells.

The Census Bureau projects that most of the new residents will come from New York — once the country's largest state but expected to drop to fourth by 2000.

Following behind New Yorkers, in order, will be newcomers from Ohio, Georgia, Massachusetts, New Jersey, Pennsylvania, Alabama and Illinois, according to the number of out-of-state vehicles registered in Florida in 1982. Now only 31.1 percent of the state's people were born here.

Elderly Floridians are expected to continue to expand their economic influence on the state, demanding improvements in health care and more rooms in nursing homes.

While seniors 65 and older make up 11.3 percent of the nationwide population, they now make up 17 percent of Florida's population with 1.7 million people.

By 2000 the elderly population is expected to increase to 2.8 million, or 19 percent.

Already in the Gulf coast counties of Charlotte, Sarasota and Pasco, 30 percent or more of the residents are seniors.

Service jobs, now one of the biggest employers because of tourism, are expected nearly to double by 2000. The industry will grow 66 percent by 1990 with a projected increase of 540,000 workers.

Already, Florida legislators are calling rapid growth and development "the single most important problem facing the state." For example, this year's new taxes for roads and schools and tougher laws to protect groundwater were the direct result of growth pressures and were considered long overdue by Gov. Bob Graham.

And as the state continues to turn pastures and groves into shopping malls and apartment complexes, Graham is emphasizing the fragile balance between growth and the environment.

"More and more, Florida seems like a lifeboat, adrift between the Atlantic Ocean and the Gulf of Mexico," he wrote in a recent magazine article.

"There is brackish water under us and all around us, but only a few precious drops of sweet water to drink. Our aquifers are our only canteen."

The art or science of managing growth has climbed from the confines of a few isolated state planners to the top of the Legislature's agenda.

Florida's population projection

Counties with population of over 100,000

County	1980	2000	Percent increase
Seminole	179,752	345,200	92.6
Lee	205,266	379,100	84.7
Palm Beach	576,863	955,400	65.6
Broward	1,018,200	1,609,300	58.0
Alachua	151,348	232,900	53.9
Leon	148,655	244,900	51.3
Orange	471,816	666,700	42.6
Brevard	272,959	377,300	38.2
Hillsborough	646,960	856,200	32.3
Escambia	233,794	277,700	18.8

SENTINEL GRAPHIC

Next year Florida's lawmakers are expected to consider dozens of growth-related issues that could drastically change the state's environmental and economic landscape.